ANNUAL REPORT

NELSON MARLBOROUGH DHB

2013/2014

TE WAI ORA

Nelson Marlborough
District Health Board

Contents

Statement from Chair and Chief Executive

It is with pleasure that we present the annual report for 2013/14.

Nelson Marlborough District Health Board (NMDHB) has in place the capability to carry out all of the functions required of it under the New Zealand Public Health and Disability Act (NZPH&D Act).

OUR VISION

In reviewing the 2013/14 year we have continued to progress towards our mission to 'work with the people of our community to promote, encourage and enable their health, wellbeing and independence'. This progress is in conjunction with the Government's objectives for improved patient and population health outcomes. The Board's commitment to being a community leader is reflected through our vision of "leading the way to health-conscious families". We have an emphasis on a more responsive, interconnected system of health, disability and support care through prevention, health promotion and reducing health inequalities in this district. This commitment is reflected in the values adopted by the Board: Respect; Innovation; Teamwork; and Integrity.

TOP OF THE SOUTH SERVICE REVIEW

The Top of the South Health Review Report has been released and can be found on the NMDHB website. The report supports the Board's commitment to having 24/7 acute, and elective services that reflect the 'one service - two site model' with equitable access to high quality services.

The report does not advocate radical revolution but an evolution of systems that bring Wairau and Nelson services closer together under 'one service - two sites'; providing equitable access to services regardless of whether you live in Nelson, Marlborough or Tasman.

While the report has taken longer than anticipated the wait has been worth it as we now have a firm platform for the DHB to work from to ensure clinically and financially sustainable, and high quality hospital service provision across the district.

Our challenge is to provide services as close to home as possible whilst best utilising our district's collective resources which means some clinicians will need to travel and some patients may be offered faster treatment but may have to travel. This does not detract from our commitment to provide core services at both Nelson and Wairau Hospitals. We are currently investigating how to support staff and patient travel across the district.

Some of the recommendations include: extending the junior medical workforce and expanding the scope of practice for nursing and allied health professionals; making senior clinical roles district-wide; employing a generalist medical workforce rather than a workforce of subspecialists; reviewing and aligning key support services of Intensive Care Units, Radiology and Laboratory to ensure we have the best fit for services provided at each site.

Implementation of recommendations from the report is one of a number of priorities for the DHB.

Other priorities include preventative healthcare, primary community healthcare and integration of services; wider workforce development, investment in clinical information technology, as well as the redevelopment of Nelson Hospital in the coming years.

TOP OF THE SOUTH HEALTH ALLIANCE

On 1 July 2013 the reformed Top of the South Health Alliance (TOSHA) took shape. TOSHA has strategic and operational oversite of all activities Primary and Community orientated. The TOSHA Alliance Leadership Team is made up of representatives of NMDHB, Nelson Bays Primary Health, and Kimi Hauora Wairau Marlborough Primary Health Organisation. More recently the General Manager of Te Piki Oranga has joined the Alliance Leadership Team. The 2013/14 year has been a period of establishment of the various alliance teams and workstreams. The priorities of the Alliance include:

- Health Pathways
- Primary and Community Nursing
- CVD / Diabetes

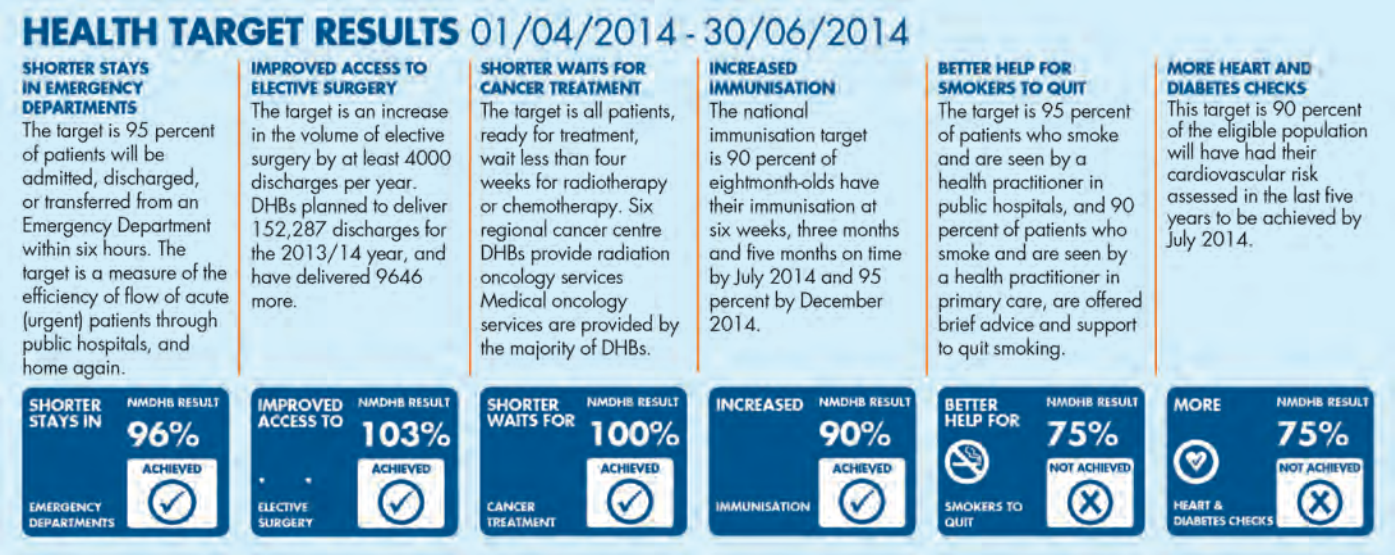
- Child & Maternal Integration Pilot
- Coordinated Response Electronic Service (CARES)
- Acute Demand Management
- Access to Diagnostics
- Medicines Management
- Rural Services

Each of the streams now have an established work program which is designed to support both incremental and transformational changes across the Nelson Marlborough Health System

FACILITY PARTNERSHIPS

During the year a new Community Health Facility was developed in Richmond which houses Nelson Bays Primary Health, Nelson Marlborough District Health Board's Public Health Services, and Te Piki Oranga. The building has been extensively refurbished by its owner, Network Tasman, and additional space is presently being added. This is a great opportunity to collocate related services to enhance planning and service development / delivery in an integrated manner. We have also committed to a similar facility in Blenheim, due to be commissioned in early 2015. These are both exciting developments where we are focussing on integrating like minded services to ensure we get maximum health gain for scarce health dollars.

HEALTH TARGETS



ELECTIVE PERFORMANCE

The DHB met the target of completing 6115 surgeries for Nelson Marlborough people by 30 June 2014. While there has been a concerted effort to get back on track after issues arose in the July to October 2013 quarter, we have now caught up and have also completed the required complexity of cases.

There is an element of risk associated with the amount of surgery other DHBs carry out for Nelson Marlborough people; the last month's data shows that not as many people as expected were treated in other DHBs, which means we will have to increase local surgery to compensate. Less reliance on these inter-district flows is a financial saving for the DHB and we encourage surgery to be completed in our own theatres.

Statistics show that NMDHB provides more than its equitable share of surgery to Nelson Marlborough people. And when age and other demographics are considered we rank fifth in the country out of 20 DHBs, providing 12% more surgery than our population would expect.

FINANCIAL PERFORMANCE

Over the course of the financial year NMDHB has moved from the $2.9 million deficit reported for the year ended 30 June 2013 to a surplus of $4.4 million for this financial year.

The DHB was placed in Intensive Monitoring in January 2013 due to the rapidly deteriorating financial performance.

However the improved performance has meant that the Ministry of Health revised the DHB's monitoring status from Intensive to Performance Watch, and early in the 2014/15 financial year this was upgraded to Standard Watch.

The recovery plan has impacted on all areas of the health system however, the DHB is now on a more steady financial footing, and for the 2014/15 year shows we are able to move forward on some investments in workforce, integration, and infrastructure.

THE YEAR AHEAD

Over the past 24 months the DHB has been through considerable challenges with respect to financial sustainability. This has resulted in a need to take steps to ensure we live within our means. As an organisation we have risen to this challenge, and it is pleasing that the Annual Plan for the 2014/15 year sets out a number of areas where we are able to invest in our future. This includes:

- Investment in initiatives that will strengthen our commitment to our 'one service - two sites' approach for 24/7 acute, and elective services in Nelson and Wairau Hospitals. The first investments are focused on workforce. The investment is the first step of many to be taken in the future.
- Investment in initiatives that will provide the opportunity to enhance the integration of primary, community, and secondary services under the umbrella of the Top of the South / Te Tau Ihu o Te Waka a Maui Health Alliance (ToSHA).
- Investment in significant initiatives through the Information Systems Alliance under the South Island Alliance umbrella which will make significant inroads in enhancing the integration of clinical information both across our district and regionally.
- Development of a Health Service Plan and Facilities Master Plan which will support the planned redevelopment of Nelson Hospital as well as providing guidance for facility investment in primary and community settings. An early facility development which is expected to commence during 2014/15 is the long awaited Learning & Development Centre on the Nelson Hospital site and the strengthening and redevelopment of the Arthur Wickes building on the Wairau Hospital site.
- Development of our Workforce Strategic Plan to guide specific activities over the next decade to ensure we have a workforce across the Nelson Marlborough Health System that is fit for purpose.

We are investing significant effort and energies to strengthen our approach to Clinical Leadership and Clinical Governance ensuring that this is integrated at all levels of the organisation, and across the Nelson Marlborough Health System.

ACKNOWLEDGEMENTS

The achievements of 2013/14 have come about because of the dedication of the loyal workforce and our primary, community, and NGO providers we have in the Nelson, Marlborough, and Tasman districts. We would like to take the opportunity to thank them for their continued commitment and support.

Jenny Black
Board Chair

Chris Fleming
Chief Executive

Governance

THE BOARD OF THE DHB

The Board, comprising seven elected and four appointed members, provides governance to Nelson Marlborough District Health Board (NMDHB).

The Board concentrates on ensuring that it operates in a financially responsible manner by setting policy and strategy, monitoring its achievement and appointing the Chief Executive to manage the implementation of this policy and strategy. All other employees are appointed by the Chief Executive.

The Board maintains open communication with the Minister of Health to ensure recognition of the Government's expectations and to report on the organisation's plans and progress.

The Board meets monthly while the advisory committees meetings rotate over a three monthly cycle with individual committee meetings followed by a combined workshop.

Since April 2011 the Community and Public Health Advisory Committee and the Disability Support Advisory Committee have met together in a single meeting.

An opportunity for the public to bring issues to the Board's attention is given in a public forum at the beginning of each Board and Committee meeting. All meetings are advertised and open to the public to attend, except where business needs to be conducted in closed sessions in accordance with criteria set out in the legislation.

The Advisory Committees have key aspects of governance that they oversee:

Hospital Advisory Committee

This Committee monitors the financial and operational performance of the hospitals and assesses strategic issues relating to the provision of hospital-based services.

Community and Public Health Advisory Committee

The role of this Committee is to provide the Board with advice on the health and disability needs of our district population. The Committee reports on anything significant that may affect our population's health and it also advises our Board on which issues are most important.

Disability Support Advisory Committee

The role of this Committee is to support NMDHB to address the New Zealand Disability Strategy, fulfil its obligations under the New Zealand Health and Disability Act 2000, and also to initiate planning and funding recommendations for disability support services for people over 65 years and the development of associated needs assessments, policy and processes.

The Board also has an Audit and Risk Committee to assist in discharging the Board's responsibilities relative to financial reporting, regulatory compliance and risk management (including clinical risk management). This Committee meets quarterly.

The Remuneration Committee meets six-monthly to review the performance of the Chief Executive.

DHB ELECTIONS

In October 2013 the triennial elections for local government were held incorporating the election of seven DHB Board members. The election resulting in some changes to the membership of the Board with the retirement or non-election of Gordon Currie, Fleur Hansby, John Inder, and John Moore. Through the election process the following new members were elected: Jessica Bagge, Jenny Black (from Marlborough), Brigid Forrest and Pat Heaphy.

These new members joined Jenny Black (from Nelson who was reappointed as Board Chair), Judy Crowe and Gerald Hope all of whom were successfully re-elected, and the ministerial appointments Ian MacLennan (who was also reappointed as Deputy Chair), Patrick Smith and Russell Wilson. Roma Hippolite was reappointed but resigned in May 2014 to be replaced by Dawn McConnell.

MEETING ATTENDANCE

NAME	BOARD	CPHAC / DSAC	HAC	COMBINED COMMITTEE
Total Meetings	**12**	**4**	**4**	**2**
Board Members				
Jenny Black	12/12	4/4	4/4	2/2
Ian MacLennan	11/12	2/4	4/4	2/2
Judy Crowe	10/12	3/4	4/4	2/2
Gerald Hope	10/12	1/2	4/4	2/2
Patrick Smith	12/12	4/4	3/4	2/2
Russell Wilson	11/12	2/2	4/4	2/2
Jenny Black (from Dec 2013)	6/7	2/2	1/2	2/2
Pat Heaphy (from Dec 2013)	7/7	2/2	2/2	2/2
Jessica Bagge (from Dec 2013)	7/7		2/2	2/2
Brigid Forrest (from Dec 2013)	7/7	2/2	2/2	2/2
Dawn McConnell (from May 2014)	1/2	1/1	0/1	
Roma Hippolite (to May 2014)	8/10	1/2	3/3	2/2
Fleur Hansby (to Dec 2013)	5/5	1/2	2/2	
Gordon Currie (to Dec 2013)	4/5	1/2	2/2	
John Inder (to Dec 2013)	4/5	1/2	1/2	
John Moore (to Dec 2013)	5/5	2/2	2/2	
COMMUNITY MEMBERS				
Jenny Black (to Dec 2013)		2/2		1/1
Judith Holmes		4/4		1/2
George Truman (to Dec 2013)		2/2		1/1
Jos Van Der Pol (to Dec 2013)		2/2		1/1
Glenys MacLellan		4/4		2/2
Luke Katu		4/4		1/2
Sonny Alesana		2/4		1/2
Jane Anderson-Bay (to Dec 2013)			2/2	1/1
Francis Gargiulo (to Dec 2013)			1/2	1/1
Dawn McConnell (to May 2014)			4/4	1/2
Jenni Gane (from Dec 2013)		2/2		0/1
Dana Wensley (from Dec 2013)			1/2	1/1
Patricia O'Brien (from Dec 2013)			1/2	1/1

DISCLOSURE OF INTERESTS

The DHB maintains an interest register and ensures Board and Executive Leadership Team members are aware of their obligations to declare interests.

All relevant and required disclosures relating to Board members' interests were affected during the year, including where an interest relates to transactions of the Board that any Board member has or may have had an interest in.

The DHB and its Board members have taken out directors' and officers' liability insurance, providing cover against particular liabilities.

There were no notices from Board members requesting to use DHB information, received in their capacity as Board members, which would not otherwise have been available to them.

INTERESTS REGISTER – BOARD MEMBERS

NAME	EXISTING – HEALTH	EXISTING – OTHER	INTEREST RELATES TO	POSSIBLE FUTURE CONFLICTS
Jenny Black (Chair)	• Life member of Diabetes NZ • Chair of South Island Alliance Board			
Ian MacLennan (Deputy Chair)	• Member of Nelson Centre of the Cancer Society of NZ • Nephew appointed in August 2013 as Acting ICT Manager (confirmed no direct / indirect involvement in process – relationship was disclosed by nephew during recruitment process)	• Finance Manager – The Heartland Group – Nelson – Apple Industry related • Trustee – The Bishop Suter Trust – a community Art Gallery	• Tenancy and IT hosting • The Heartland Group • The Bishop Suter Trust	• Accommodation for the Cancer Society
Gerald Hope		• Executive Officer Marlborough Research Centre • Director Maryport Investments Ltd	• Landlord to Hills Laboratory Services Blenheim	
Judy Crowe	• Chairperson of Nelson Marlborough Hospitals' Charitable Trust • Son-in-law is locum gastroenterologist at Capital & Coast DHB	• Member of the Gladys Amelia Pascoe Trust	• Provision of trust funds towards equipment, training and patient support	
Patrick Smith	• Member of Iwi Health Board	• Managing Director, Patrick Smith HR Ltd • Member on Board of Nelson Tasman Chamber of Commerce • Shareholder, Kimi Human Resources	• Consultancy services • Contracts held • HR business with a focus in primary industries and Maori Services	• Focus on primary sector and Maori working with Maori Health Providers who hold contracts

NAME	EXISTING – HEALTH	EXISTING – OTHER	INTEREST RELATES TO	POSSIBLE FUTURE CONFLICTS
Russell Wilson		• Member of NZ National Party (Regional Office holder) • Managing Director of Carat Investments • Principal Consultant at Wilson Consultants (HR and Business Management consultancy)	• NZ National Party • Carat Investments • Wilson Consultants	
Jenny Black (Marlborough)	• Part Time NMDHB Employee • ACP Practitioner		• DN Team Wairau	
Pat Heaphy		• Relative is employee of NMDHB • Spokesperson Knights of Southern Cross • National Spokesperson Opposing Euthanasia	• Nurse	
Brigid Forrest	• Contractor to NMDHB • Doctor at Hospice Marlborough Employed by Salvation Army • Locum GP Marlborough (not a member of PHO) • Base Medical Officer RNZAF Woodbourne (Part time). Employed by Picton Medical Centre		• Community Geriatrician Wairau	
Jessica Bagge	• Save our Services/ Hands Off Wairau	• Marlborough District Council • Marlborough Signs & Design Ltd	• Was a spokesperson and co-leader • District Councillor • Signwriter	
Dawn McConnell	• Board Member, Kimi Hauora Wairau PHO		• Contracts held	
Fleur Hansby	• Son is employed by NMDHB as house surgeon at Wairau Hospital • Son is a member of NZ Medical Council • Disability Funding from ACC		• Family member • Self	
Gordon Currie	• Member NZ Board GreyPower		• Residents over 50 years	

NAME	EXISTING – HEALTH	EXISTING – OTHER	INTEREST RELATES TO	POSSIBLE FUTURE CONFLICTS
John Inder	• Board Member St Mark's Society		• Alcohol and other drug residential treatment. NGO part funded by NMDHB	
John Moore		• Member Nelson Regional Land Transport Committee • Trustee of Top of the South Athletics Charitable Trust		

INTERESTS REGISTER – EXECUTIVE LEADERSHIP TEAM

NAME	EXISTING – HEALTH	EXISTING – OTHER	INTEREST RELATES TO	POSSIBLE FUTURE CONFLICTS
Chris Fleming (Chief Executive Officer)	• Director of Health Benefits Limited • Lead Chief Executive, Health of Older People Services workstream for South Island DHBs • Lead Chief Executive, Health of Older People Services workstream nationwide DHBs • Chair of South Island Alliance Leadership Team • Trustee of Churchill Trust • Trustee of Nelson Marlborough Hospitals' Community Trust			
Nick Baker (Chief Medical Officer)	• Sr Clinical Lecturer, Community Child Health, University of Otago, Wellington School of Medicine • Member, Steering Group NZ Child and Youth Epidemiology Service (previously Chair of and co-founder of the service) • Chair, NZ Child and Youth Mortality Review Committee • Member, Child and Youth Network Advisory Group – MOH/PSNZ/NHB • Member, NZ Paediatric and Child Health Committee Royal Australasian College of Physicians • Instructor for Advanced Paediatric Life Support NZ • Technical Advisor, Whakawhetu National SUDI prevention for Maori • Chair, South Island Child Health Alliance	• Wife is a graphic artist who does some health related work		

NAME	EXISTING – HEALTH	EXISTING – OTHER	INTEREST RELATES TO	POSSIBLE FUTURE CONFLICTS
David Bond (Associate Chief Medical Officer)				
Peter Bramley (GM Clinical Services)				
Robyn Byers (GM Mental Health)				
Hilary Exton (Director of Allied Health)				
Ros Gellatly (Chief Medical Advisor Primary)				
Robyn Henderson (Director of Nursing & Midwifery)				
Sharon Kletchko (GM Strategy, Planning & Alliance Support)	• Member Exceptional Circumstances Panel – PHARMAC • Chair, Medicine's Review Committee (Medicine's Act) MEDSAFE • Chair National GMs Planning & Funding Network • Chair Regional GMs Planning & Funding Network	• Member New Zealand Standards Council		
Patrick Ng (GM IT & Infrastructure)				
Keith Rusholme (GM Disability Support Services)	• Wife is a provider of complementary health services • Sister works for DSS		• Possible provision of services to DHB staff	
Eric Sinclair (GM Finance & Performance)	• Trustee of Golden Bay Community Health Trust			• Wife is a Registered Nurse (not currently practicing)
Heather Smith (GM Human Resources)				
Karen Vaughan (GM Clinical Governance Support)				
Harold Wereta (Director Maori Health & Whanau Ora)	• Ngati Toarangatira Connections • Ngati Koata		• Tribal Interest	

Iwi Health Board

2013/14 was marked by change. The NZ Public Health and Disability Act 2000 creates the commitment for the Iwi Health Board and the DHB to work closely in partnership to support our obligations under the Treaty of Waitangi.

Eight Iwi make up the Manawhenua O Te Tau Ihu and Maataa Waka: Ngati Apa, Rangitane, Ngati Koata, Ngati Kuia, Ngati Rarua, Ngati Tama, Ngati Toarangatira, Te Atiawa and Maataa Waka. Membership is appointed to the Iwi Health Board.

Key Messages

- *Strengthening Maori leadership*
- *Greater focus on Maori health outcomes*
- *Better positioning of Maori health to meet tomorrow's generation*

National Maori health Targets

- *Achieved breast screening (50-69yr) target*
- *Within 10% of target for ASH (0-74yr), Full or exclusive breastfeeding (3m), cessation advice (hosp), & immunisation (8m)*
- *Within 20% of target for PHO enrolment, ASH (0-4yr), ASH (45-64yr), full & exclusive breast feeding (6m) Cervical screening(25-69yr), & cessation advice (primary care)*
- *Greater than 20% or non-compliance to target for full & exclusive feeding (3w and 6m) & CVRA rate care)*
- *There have been overall improvements*

Josephine Faragher resigned as the member for Ngati Kuia and she was replaced by Rebecca Mason. Otherwise, the membership to IHB remains unchanged from the previous year.

Iwi remains committed to delivering advice to the DHB through representation on the DHB Board statutory sub-committees. Another important vehicle available is that the IHB and the DHB Board meet twice a year and this has created an important forum where strategic issues like the Maori health provider coalition and Maori health outcomes reporting are discussed and agreed to.

The major decision was the DHB Board approving in November 2013 the Maori health provider coalition business case which was supported by IHB through a majority vote. It was disappointing that two Iwi did not support the decision, however Te Piki Oranga remain committed to working with all Iwi across Te Tau Ihu. This milestone paved the way for the establishment of a new Maori health provider Te Piki Oranga (TPO). TPO Board is drawn from six Maori health providers with Te Hauora O Ngati Rarua deciding to withdraw from the process. Staff and clients have been transitioned into new provider and the DHB has confirmed a three year contract. The change will introduce a Whanau Ora framework designed for Nelson Marlborough. It introduces community nursing, social workers and community health navigation and works towards Maori potential. The model moves away from activity based services (e.g. disease statement) and establishes an outcomes framework based on Results Based Accountability. This new method measures health based on population improvements and service measures which respond to three questions – How much did we do (Quantity), How well did we do it (Quality) and Is anyone better off (Client results).

An area of focus for IHB has been the Maori health plan 2013/14 and the dashBoard developed by the National Maori General Managers forum Te Tumu Whakarae. The results show that NMDHB has improved when compared to 2012/13. Overall, the DHB exceeded the breast screening (50-69y) target at 82% (National target 70%). Other important results there were four targets within 10% of the national target. They included ASH (0 – 74y) at 2,694 (national target 1971), Full or exclusive breastfeeding (3m) at 49% (national target 54%), cessation advice (hosp) at 92% (National target 95%), & immunisation (8m) at 86% (national target 90%). Both the DHB Board and IHB will be looking to achievement further improvements in succeeding years.

Maori health planning continues to be an important focus for IHB. The Maori health action plan for 2012/13 shows Nelson Marlborough DHB is placed at the mid-range of district health Boards in achieving the national targets. For example, the DHB exceeded its breast screening target at 82% (national target 70%) and there

were three targets within 10% of the national target. They include ASH (45 – 64yrs) at 2320 (National target 1661), cessation advice (hospital) at 94% (National target 95%, and immunisation at 81% (national target 90%). Overall, there is room for improvement by NMDHB.

The IHB continues to have strong commitment to improving Maori health across the district. They are particularly focused on the Maori clinical workforce, and growth within the regulated and non-regulated workforce. Of particular interest will be the embedding of the new Maori health entity Te Piki Oranga and the way services will be delivered under the new Whanau Ora framework for the Nelson Marlborough districts. As the services to Maori grow, so too will the potential to show improved health gain to those with the greatest need. The results based accountability framework prepared for Te Piki Oranga will provide the start point for measuring this success.

The IHB have also supported the strengthening of the relationship with the Nelson Marlborough Institute of Technology. A strong focus was on working with the Departments of Nursing and putting in place, through the DHB, mechanisms to support Maori nursing students from year one to year three. This is a work in progress as the focus is toward improved pathways that will allow these Maori graduands to move into the workforce.

For 2014/15 the IHB will continue to strengthen Maori leadership in health, have greater focus on Maori health outcomes, and better position Maori health to meet tomorrow's generation. It will continue to closely monitor the DHB through the Maori health targets, review the 30 year Maori health & wellness strategic framework, and further support and offer direction on Maori health to the Nelson Marlborough DHB Board.

Our Community

What We Can Learn From the 2013 Census

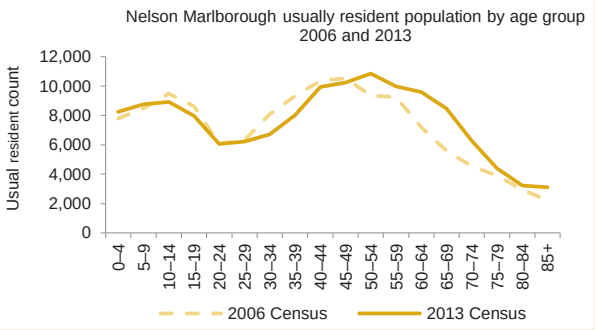
The census was held on the 5th of March 2013—two years after it was cancelled as a result of the 2011 Christchurch earthquake and seven years after the previous census. The census is a snapshot in time that indicates how the profile of our population is changing. Consideration of these changes is crucial to the planning of future health services in Nelson Marlborough.

Our Growing Population

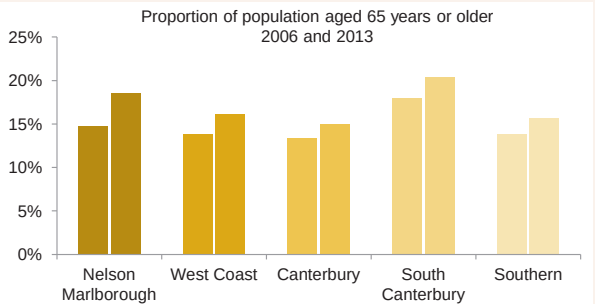
Our usual resident population has increased by 5.3% since 2006, the highest growth of any DHB in the South Island. The largest growth in the region has occurred in Nelson City.

There has been an increase in migration from Christchurch since 2006. There are 780 more Nelson Marlborough residents who were living in Christchurch five years ago than for the same period at the 2006 Census. Almost all of this additional migration from Christchurch has been to the Tasman District and Nelson, rather than the Marlborough District.

Our Ageing Population



We are continuing to see our older residents making up a greater proportion of our population. 18.6% of our population are now aged 65 years or older. This has increased from 14.7% in 2006. In fact, Nelson Marlborough has experienced the highest growth in older population of any DHB in the country.



TE WAI ORA
Nelson Marlborough District Health Board

136,995 residents*

5.3% **increase** in our resident population since 2006

18.6% of our population are aged **65 or older.**

Nelson Marlborough had the highest growth in older population of any DHB in the country between 2006 and 2013.

9.4% of our population are **Māori**

13.9% of those aged 15 years or older smoke regularly, down from 19.3% in 2006.

30.4% of Māori smoke regularly. This has dropped from 39.7% in 2006.

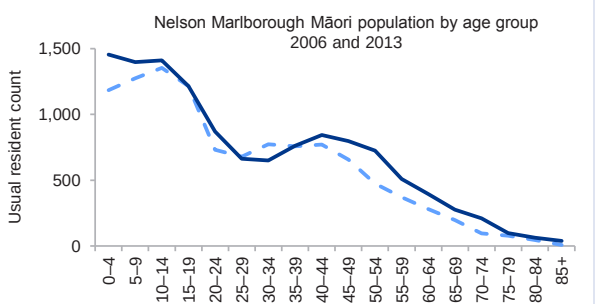
13.9%

25.2% of households have only one resident. This is an 11.9% increase since 2006.

2.2% **increase** in the number of **families** with dependent children since 2006.

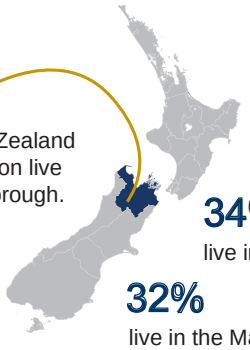
Our Ethnic Diversity

There has been an increase in ethnic diversity in Nelson Marlborough since 2006. 9.4% of our population now identify as Māori, up from 8.7% in 2006. Our Māori population are much younger than our general population, with 45.9% of our Māori population under the age of 20. This is considerably higher than our non-Māori population (22.8%). Our Māori population live in areas of higher deprivation than our non-Māori population. However, our Māori population are less deprived than Māori nationally. There are also increased proportions of our population identifying as Asian and Pacific ethnicities than in 2006. 3.1% of our population now identify as an Asian ethnicity and 1.7% of our population now identify as a Pacific ethnicity.



Our Population by District

2006 Census — 2013 Census



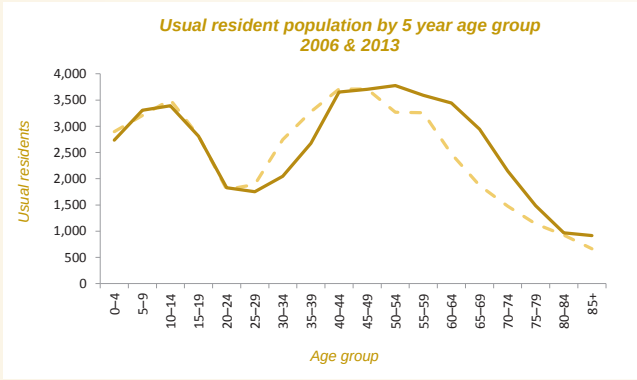
3.2%
of the total New Zealand resident population live in Nelson Marlborough.

34%
live in the Tasman District.

34%
live in Nelson City.

32%
live in the Marlborough District.

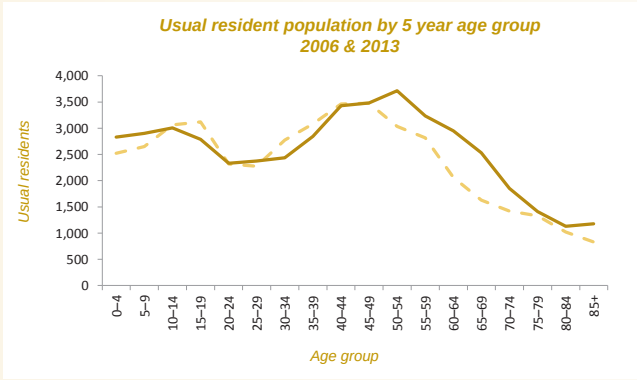
Tasman District



1.8%
of Tasman households do not have access to any form of telecommunication system, the highest proportion of any district in Nelson Marlborough.

20%
of Tasman residents are aged under 15.

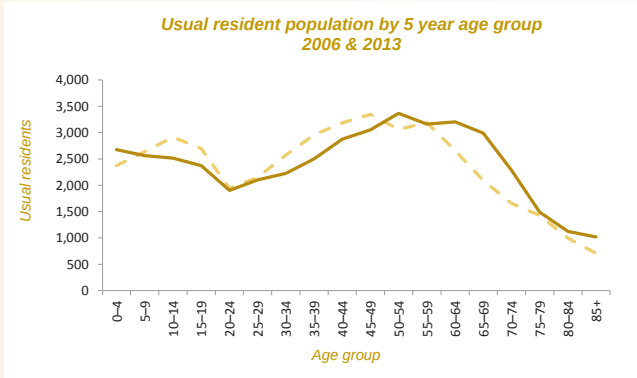
Nelson City

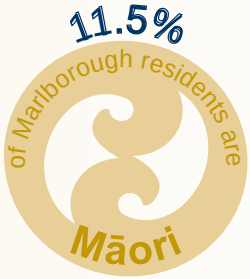


8.3% increase
in resident population of Nelson between 2006 and 2013. This is the highest growth of any district in Nelson Marlborough.

4.3% increase
in the number of families with dependent children between 2006 and 2013. However, there has been a reduction in the number of single-parent families with dependent children.

Marlborough District





20.5%
of Marlborough residents are aged **65 or older.**

This is the highest proportion of any district in Nelson Marlborough.

08.1-2

Clinical Governance

The Clinical Governance Committee has been established and a new Terms of Reference approved.

The key actions for the committee in the first year are as outlined in the Annual Plan for which action plans have been developed. Once the committee has approved the action plans there will be the allocation of champions for each element to work across the service delivery units to achieve the actions outlined within the plans.

There will also be specific focus on several other clinically led initiatives such as medication errors, fall's and other quality markers. In addition there has been a schedule of reporting from sub-committees developed over the upcoming year where they will attend the committee meetings to present their current work plans.

Whilst it is acknowledged there is much to do pro-actively across the organisation to achieve continuous quality improvement, it is always important to ensure learning's from events are embedded into the services and recommended changes initiated and followed through with ongoing audit providing the required assurances that compliance with clinical policy and process is achieved.

The Clinical Governance Group has made significant progress in the first six months of this calendar year through reviewing and implementing a new system for managing complaints and serious event investigation.

Alongside the above continues the work with the pro-active quality initiatives and projects. The new patient experience system will provide valuable information to the organisation from a larger group of consumers as to how as an organisation we delivered services and how we met their expectations.

The Clinical Governance Committee is focussed primarily on the functions of the hospital and other provider arm activities, however it is forming a close relationship with the two Clinical Governance Committees of the two Primary Health Organisations. Over time it is expected that these three committees may converge into a Clinical Governance Committee across the Nelson Marlborough Health System.

The Clinical Governance Committee will also be looking at how we report monthly and what we report through to the Board. We invite the opportunity for the Board to provide commentary in what they would like to see from a reporting perspective monthly to be included in this report.

INVESTING IN THE DEVELOPMENT OF CLINICAL LEADERS

NMDHB has recently strengthened clinical leadership across the organisation with the creation of a General Manager Clinical Governance Support role. The purpose of the role is to support NMDHB and the formalised senior Clinical Leadership positions to develop and maintain a robust clinical governance environment which ensures the organisation is accountable for continuously improving the quality of our services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish. As a member of the ELT this position has dual accountability for the effective leadership of NMDHB and the leadership of the Clinical Governance Committee.

NMDHB has also created an Associate Chief Medical Officer role to supplement the role of Chief Medical Officer and ensure district wide coverage, and has appointed Clinical Directors representing specialist areas. A newly created position of Chief Primary Care Medical Advisor has also been created which will ensure that there is strategic input from primary care at all levels of the District Health Board. This role will work closely with our two Primary Health Organisations to facilitate input as opposed to being the input necessarily itself.

Clinical champions have been active in the 'Open for Better Care' patient safety campaign at NMDHB.

Clinicians were also involved in the development of the first Quality Account for NMDHB, an annual report about the quality of the healthcare services provided to the community, and how the NMDHB is progressing in terms of continuous quality improvement, the consumer experience and health outcomes.

INVOLVING THE WIDER HEALTH SECTOR (INCLUDING PRIMARY AND COMMUNITY CARE) IN CLINICAL INPUTS

The NMDHB Clinical Pathways initiative facilitated by the DHB and the two PHOs in the district is key mechanism for enabling hospital and community clinical staff to engage in clinical inputs.

NMDHB's Clinical Governance Committee has clinical community care representation, and community

healthcare providers are able to notify NMDHB of reportable events in the community and provided feedback using the Health Pathways system.

In November 2013 NMDHB hosted the Nelson Marlborough Health Quality & Innovation Awards. The awards are a two-yearly event and were established to heighten awareness of initiatives by health employees and health providers across the Nelson Marlborough district, with a view to showcasing continuous quality improvement leading to improved patient care. NMDHB is leading the drive for excellence in health care in the district and is committed to using these Awards as one means of highlighting the quality message. The Awards are open to all health providers in the Nelson Marlborough district who are funded by the NMDHB.

DEMONSTRATING CLINICAL INFLUENCE IN SERVICE PLANNING

NMDHB has undertaken an organisation wide review of services with the objective of providing patients with a more joined up health care system that is more responsive to their needs and puts greater emphasis on giving the right treatment at the right time in the right facility. The recommendations from the review support the 'one service - two site' model where patients across the Top of the South have access to high quality services. The report proposes greater Board/Management presence at Wairau Hospital to improve clinical governance and inclusivity and so far appointments are: Associate Chief Medical Officer and Associate Director of Nursing/Operations Manager and the Service Manager Surgical Services based in Wairau.

NMDHB has also conducted service specific reviews with strong clinical and consumer input. Examples are a review of the Rheumatology service and the Maternal and Child Health project. The Maternal and Child Health project team are currently putting together a consumer panel of interested people who would like to participate in the development of the project concepts, and talk about what does and does not work for them with regard to maternal and child health services in our area.

INVESTING IN PROFESSIONAL DEVELOPMENT

There are professional development programmes in place for all clinical groups across the DHB.

In October 2013 NMDHB provided an interactive clinical ethics forum for all staff. Dr Alastair MacDonald, Chair of the Capital & Coast DHB Clinical Ethics group, provided an introduction to clinical ethics and then worked through some situations that have faced health professionals in their work at NMDHB.

NMDHB also sponsored clinicians to participate in the APAC forum on quality improvement in healthcare, with the aim of providing a seamless healthcare experience for providers and patients.

INFLUENCING CLINICAL INPUT AT BOARD LEVEL AND ALL LEVELS THROUGHOUT THE DHB – INCLUDING ACROSS DISCIPLINES. WHAT ARE THE MECHANISMS FOR PROVIDING INPUT?

NMDHB's Clinical Governance Committee is chaired by the Associate Chief Medical Officer, and consists of senior clinicians, including PHO representation, who report via the Chief Executive to the Board on a monthly basis. The Committee has oversight of all clinical standing committees across the organisation including Credentialing, Pharmacology and Therapeutics Advisory Committee (PTAC), Regional Transfusion, and the Local Child & Youth Mortality group.

The CMO briefs the Board's Audit & Risk Committee at every meeting.

The Executive Leadership Team, through the Chief Executive, provides the Board with reports, information and data on which to make strategic decisions. The Board and its Advisory Committees also regularly receive presentations from clinicians on key service/clinical issues.

SMO ENGAGEMENT AND DISTRIBUTIVE CLINICAL LEADERSHIP

Under the auspices of the Top of South service review the first combined meetings of our clinical teams have taken place in Havelock. Three meetings have brought together senior medical staff from both Nelson and Wairau who work within the specialist areas on which the review focussed, General Medicine/ Cardiology, General Surgery and Orthopaedics. Each meeting was facilitated by the CMO and ACMO, and attended by the Service Managers for each service. An action plan has been developed following each review. A further development for each service is the suggestion that regular multi-disciplinary, cross DHB meetings be convened to ensure service delivery and planning become the shared responsibility of the whole clinical team and not just those in formal clinical leadership positions.

The Heads of Department (HOD) forum, having taken time to establish itself, now has wider representation and encompasses those specialist areas that haven't previously had formalised head of department roles. In particular, representation from Wairau general surgery, anaesthetics and orthopaedics has been encouraged. This will help the HOD forum to broaden its scope, but also ensure that it becomes a vehicle for change.

The Theatre Governance Group has been established and meets on a monthly basis, and includes representation from our surgical teams from both sites – both senior medical staff and the theatre charge nurses.

A number of work streams have been established under the auspices of ToSHA. These are all chaired by a Clinical leaders, and all require clinical engagement to help bring together services across both primary and secondary care.

A Wairau trauma mortality and morbidity has been established to meet on a quarterly basis following a visit from Dr Ian Civil in 2013. Local trauma calls are audited and collectively discussed by the multi-disciplinary team (including anaesthetics, ED, and general surgery). The ACMO currently chairs this group, and attempts to link learning and training with current service delivery is underway.

The Paediatric team in Wairau is engaged with community partners and a team from the Ministry of Health in the process of establishing a children's team in Blenheim and Picton. This will require direct senior medical staff involvement for it to function. It is also benefitting from the input of our CMO who is involved in the development of children's teams on a national basis.

A SMO committee has been established at Wairau as a forum to raise and discuss a range of issues pertinent to the Wairau SMO body.

CONTRIBUTING TO REGIONAL CLINICAL LEADERSHIP THROUGH NETWORKS

NMDHB clinical staff actively participate in regional clinical leadership activities including:

- The CMO/DONM/Director of Allied Health are all active members of their South Island professional networks
- A Nelson Paediatrician chairs the South Island Child Health Alliance, and other clinicians are members of other Alliance Service Groups
- The General Manager Clinical Governance Support and a Clinical Director representing primary health in the region participate in the South Island Quality & Safety SLA
- The joint process of Health Pathway development across the South Island DHBs is proving a valuable to link and support clinical leaders
- The joint process of implementing a common Incident Management system across the South Island has required the active participation of clinical staff.

Key Achievements in Services Delivered by NMDHB

CLINICAL SERVICES

Clinical Services in 2013/14 has provided for the community a wide range of acute and elective services. In an environment of increasing co morbidity, an ageing population and rising complexity the clinical teams have delivered exceptional care with some of the best health metrics for the country.

The team delivered the elective surgery required to meet the expected number of elective surgical discharges, as well as maintained the 5 month target that no one waits longer than 5 months for either a first specialist assessment or an elective procedure once accepted to the waiting list.

We also ensured we met the expected waiting times for Cancer radiotherapy, and made significant progress in improving the waiting times for Angiography, CT, MRI and Endoscopy.

Many initiatives were undertaken over the year to improve both the quality and efficiency of our service provision.

In General Surgery a programme was successfully undertaken to improve care and recovery for patients following surgery. Orthopaedics has begun a similar programme.

There have been significant changes made to our Endoscopy service with new equipment, new software to support the reporting of procedures, more staff and changes to the way referrals are managed to ensure equity of access and improved wait times.

A number of initiatives have been undertaken in our Emergency Departments to enable the team to better support people who present to the service. We have put both physiotherapy and social work resource at the front door to better assess and support patients. The ED and IT team together developed piece of software to better support patient care in our Emergency Departments. This software will be utilised across the South Island hospitals.

In 2013/14 significant reviews were undertaken. Our Clinical Support service structure was extensively changed to strengthen the teams that undertake the administration in support of clinical service.

We also had the Top of the South Service review which has set the scene to deliver stronger and more sustainable services across our district. The focus initially is on strengthening General Surgery, Orthopaedics and General Medicine.

Over this year we have been attempting to deliver more of our services closer to home for patients and where possible move services to their home of care. More skin lesion removals are now being done in primary care rather than in hospital, along with IV treatments preventing a visit unnecessarily to a hospital. One of the exciting initiatives is the development of a Rheumatology service that is multidisciplinary using specialist, nursing and GP resources but based in the community.

We have seen significant improvement in quality initiatives like reduced number of falls in a hospital setting, reduced cancellations on day of surgery, reduced rates of infection and pressure injuries.

Our child and maternity teams are part of two significant initiatives. Firstly, the Maternal and Child Integration Programme which brings together lots of community agencies to improve the health and support of mothers and children and secondly, Marlborough has been selected as one of the next sites for the formation of a Children's Team which we are fully involved in.

MENTAL HEALTH

The Mental Health and Addictions service continues to demonstrate its effectiveness in broadening regional and inter-agency strategic relationships, as well as initiating service developments and quality improvements within the service and across the wider DHB Services, and in remaining within budget. Consistent with its philosophy, it is client centred, whanau inclusive and collaborative, with achievements spanning prevention, early detection and management, intensive assessment and treatment, rehabilitation and support, and linking

across the spectrum of client needs and locations. Nelson-Marlborough rated 82% in the national Mental Health Consumer Satisfaction Survey (national average 78%).

Some examples of the areas of strategic and service development where the service has been actively involved during the year are:

- "Down on the Farm" rural mental health education programme (including Banks, Insurance, Fonterra);
- Marlborough and Nelson Councils Legal High Policy setting
- the District Youth Offending Team (Action Plan for Drivers of Crime)
- The regional COPMIA service development
- Developing the new Youth Forensic Regional (Hub and Spoke) Service as well as regular participation in the South Island Mental Health Alliance and National Projects e.g. CAMHS KPIs
- Child and Youth Community Liaison (working with Colleges)
- Establishing school based emotional regulation groups (suicide prevention)
- Psychiatric Liaison in NPH
- Specialist Units' "ASK" Wall (Access – Support – Key Information for Whanau)
- Increasing youth primary mental health access
- Parents of Depressed Teens Groups
- Anxiety Management Group (Primary)
- Addictions interventions for Youth (Primary)
- Kids in Care package
- Establishd the Addictions Consumer Group
- "Smashed & Stoned" and "Plan B" AOD School Programmes
- Marlborough postnatal depression counselling
- Established the ongoing Walking in Another's Shoes training for Mental Health Older Person Providers and a Liaison role
- The Sensory Modulation initiative (reducing seclusion and restraint) and extending it to the Community
- Bipolar Education Group run by a Consultant Psychiatrist at Nikau House
- A single shared Workforce (PHO, Specialist and NGO) training programme (including Tikanga Maori and Pacifica)
- Home based detox for babies born with addictions
- Establishing a metabolic monitoring process for long term clients

Three notable awards achieved during the year are the National Blueprint Leadership Award for service improvement in the Adult Inpatient Unit and a DHB "Collaborating for Health Improvement" Quality Award for the Co-Ordinated Access Response Electronic System (C.A.R.E.S), which was also selected and nationally presented by the MOH as one of four best practice Mental Health and Addiction Service innovations and continues to generate widespread support locally and national interest.

A significant event was the placement of the outstanding Pounamu Kohatu "Te Aroha o hinengaro" in the Waihi Oranga by Princess Hart.

The service is well positioned for the 2014/15 year having achieved the priorities identified in the 2013/14 Annual Plan all of which align to the National Mental Health and Addiction Service Development Plan, the Regional Mental Health Services Plan, the Prime Minister's Youth Mental Health Project and Welfare Reforms.

DISABILITY SUPPORT SERVICES

The 2013/14 year has been a very busy time for the service and its staff as it meets the challenges provided by business as usual whilst at the same time commencing the redefinition of the service through the implementation of external and internal review recommendations, continuing the refocus of DSS to ensure that

the people we support are our core focus, to work on the future ownership of the service and to ensure the service is financially viable as a service within NMDHB.

The staff of DSS have worked well during these busy times, without their commitment and support we would not have been able to achieve what we have for the people we support. For those who visit the people we support in their homes it is obvious that they are well supported and happy.

DSS has been working to five performance areas that are aligned to five working principles, service user centred, staff supportive, evidence based, system minded, funding fit to ensure we have the right focus on the right priorities.

Some of the key achievements for the service include:

- Service provision to the people we support has been reviewed to ensure our priorities for service development are person centred. This is a key focus which is requiring a change to the service focus and a reassessment of how we support people to ensure they have maximum independence and choice so that they can lead fulfilling lives.
- External and internal review recommendations have been implemented.
- The services management team has been restructured.
- All policies and guidelines have been reviewed.
- We exceeded our budgeted contribution to overheads by $680k. Currently if DSS was an independent organisation the service would be financially viable for the short term at least.
- Employed a new position of Practice Leader: Behaviour support. The purpose of the position is to assist staff to develop an evidenced based approach to assisting the people we support who suffer the impact of their challenging behaviours. A training manual for behaviour support has been developed and is currently being used to train DSS support staff working.
- A training and support program for managers has been developed and implemented. All managers are involved. All other training packages have been reviewed and adjusted to ensure they are in line with modern service provision.
- Of the 21 key performance targets 13 (61%) were fully achieved, good progress has been made for the remaining 8 target.
- Planning is well underway for centralisation of rostering and the placement of computers in the majority of houses to improve communication and allow greater efficiency for the payroll/roster system.
- We are currently reviewing the most appropriate future business structure for the DSS service.

INFRASTRUCTURE

A key focus for our infrastructure team has been to seek final clarification of the earthquake performance of our buildings and to take action to improve performance as required.

A detailed seismic assessment of our 'Arthur Wicks' multi-storey structure at Wairau hospital in Blenheim concluded that the building's performance needs improvement so that we can be confident of its performance in a severe earthquake. Consequently, our Engineers have provided us with design options and an indicative quotation for the completion of strengthening works. We have commenced with the next phase, a detailed design phase, prior to undertaking strengthening works, which are due to start mid-way through the coming year.

The first floor of the Arthur Wicks building is currently used for various management and administration functions. As the first floor will need to be stripped and 'made good' during the strengthening work, we have organised a user group who we are consulting with to determine the ideal layout of the first floor. The newly fitted out first floor should provide our management and administration staff with a modern, light, open plan

facility in place of the dated layout and decor that is currently in place.

We also commenced more detailed assessment of our other structures, and subsequent actions, as required, are expected to commence in the coming year.

The re-development of Wairau hospital in Blenheim left a number of small issues that have needed remediation or equipment replacement. A business case to enhance the building control system, and to replace chillers and coolers was approved and work has commenced on addressing these residual issues with the re-development.

Work commenced on developing a 'Request for Information', RFI, for the development of a 'Health Services Plan', which will in turn inform a 'Facilities Master Plan' that will allow us to plan the redevelopment of the Nelson site. It is anticipated that a respondent will be selected in the coming financial year and that the exercise will provide sufficient information for us to be able to start to develop a business case for facility re-development at Nelson. Redevelopment would be a significant programme likely to be delivered over a number of years once a business case had been completed and had received the necessary approvals.

The facilities team have also progressed with our plans to dispose of a number of DHB properties that are now surplus to requirements, with 5 houses in Stoke, Nelson successfully sold, and a number of other property initiatives indicated to the Board earlier in the year are underway.

Our People

A skilled, supported and responsive workforce is essential for sustainable service delivery. The DHB needs the right mix of trained and qualified people in sufficient supply and working in partnership with each other.

Trusting, valuing and fully engaging health professionals improves patient care and job satisfaction and will assist in recruitment and retention. Focusing on improving clinical workforce retention and fostering clinical leadership continues to be a key priority for the DHB.

The DHB is committed to continuing to support and grow clinical leadership by supporting clinical governance of the patient journey across primary and secondary services.

GOOD EMPLOYER

A key value of the DHB is to be a good employer. The DHB embraces the 7 Key Elements of 'the Good Employer' as prescribed by the EEO Commissioner. The elements are:

- Leadership, Accountability and Culture
- Recruitment, selection and Induction
- Employee Development, Promotion and Exit
- Flexibility and Work Design
- Remuneration, Recognition and Conditions

» Harassment and Bullying Prevention

» Safe and Healthy Environment

The DHB has an equal employment opportunities focus within the relevant polices. A rigorous recruiting and selection procedure is followed to ensure fairness and equal opportunity. Training and Development opportunities are offered to all staff, and personal performance and development plans are a requisite for all employees.

The DHB has a zero tolerance policy to bullying and harassment. This is supported by a Harassment and Bullying Policy and frequent training sessions for all employees on dealing with bullying and harassment.

Approximately 92 per cent of employees are covered by collective employment agreements (CEA). All the CEA's have prescribed remuneration, recognition and conditions clauses. The DHB has a similar approach for those employees on individual employment agreements to ensure fairness and equity in remuneration, recognition and conditions across the DHB.

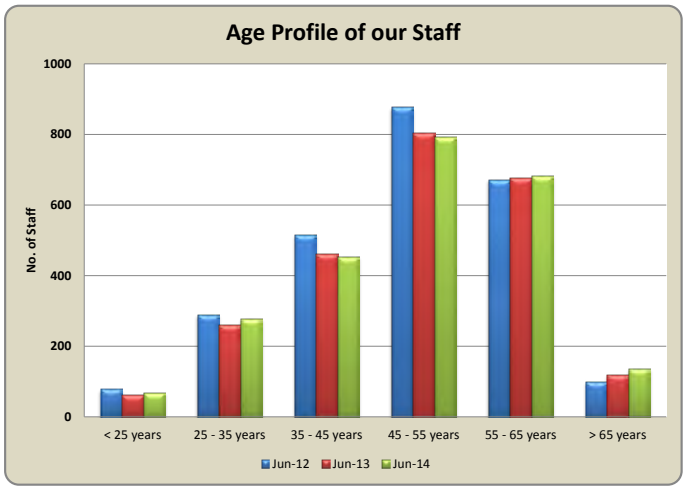
The Protected Disclosure Act 2000 and the Board's related policy, protects the right of employees to raise matters of public concern in a safe and appropriate manner. Where an individual may feel personally disadvantaged there are established grievance procedures available including external mediation or the mechanisms covered by the Employment Relations Act 2000. Employees also have 'no questions asked' access to the employee assistance programme.

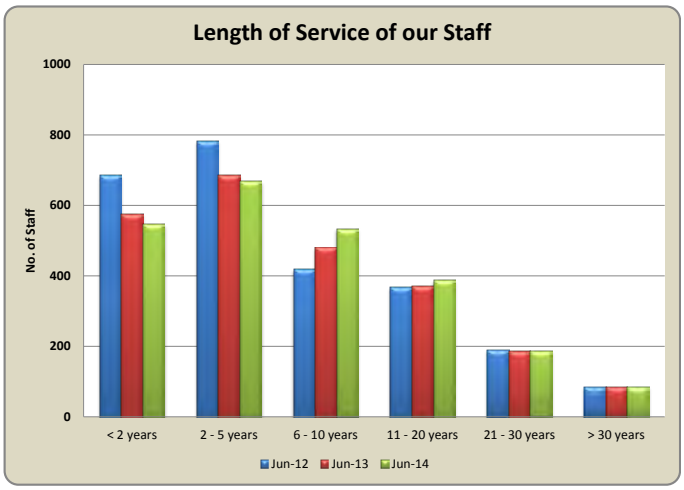
WORKFORCE PROFILE

The following provides a summary of the DHB's workforce:

EMPLOYEE GROUPING	JUN-12	JUN-13	JUN-14
Medical	181	180	183
Nursing	652	640	642
Allied Health	310	312	303
Disability Support Services	273	270	265
Hotel and Support	99	95	97
Management/ Administration	338	340	325
Total	**1853**	**1838**	**1815**

ETHNICITY	JUN-12	JUN-13	JUN-14
Asian	29	28	34
Australian	33	31	30
European	209	217	231
Maori	82	85	80
NZ European/Pakeha	1674	1562	1579
Other	51	47	53
Pacific Peoples	4	3	3
Unknown/Unspecified	450	414	401
Total Staff (Headcount)	**2532**	**2387**	**2411**





TERMINATION PAYMENTS

During the year, the DHB made the following payments to former employees in respect of the termination of their employment with the organisation. These payments include amounts required to be paid pursuant to employment agreements in place, with the majority of payments being either redundancy or retirement gratuities. The payments made by the DHB during the year totalled $768,990 to 23 employees (2012/13: 37 payments totalling $874,006).

REMUNERATION OF EMPLOYEES

The number of employees earning more than $100,000 is detailed in the table below. Of the 217 employees shown, 177 are or were medical, dental, nursing or allied health employees (174 in 2012/13).

SALARY BAND ($000S)	2014	2013
100-110	29	37
110-120	34	28
120-130	8	18
130-140	7	8
140-150	1	10
150-160	6	11
160-170	3	4
170-180	10	3
180-190	9	6
190-200	4	14
200-210	5	6
210-220	16	8
220-230	6	7
230-240	6	6
240-250	8	7
250-260	12	8
260-270	9	7
270-280	4	10
280-290	9	3
290-300	4	4
300-310	6	1
310-320	2	4
320-330	1	2
330-340	3	1
340-350	3	0
350-360	0	1
360-370	0	1
370-380	0	0
380-390	2	1
390-400	0	0
400-410	1	1
Total	**208**	**217**

Independent Auditor's Report

To the readers of Nelson Marlborough District Health Board's and group's financial statements and performance information for the year ended 30 June 2014.

The AuditorGeneral is the auditor of Nelson Marlborough District Health Board (the Health Board) and group. The AuditorGeneral has appointed me, John Mackey, using the staff and resources of Audit New Zealand, to carry out the audit of the financial statements and non-financial performance information of the Health Board and group on her behalf.

We have audited:

» the financial statements of the Health Board and group on pages 57 to 99, that comprise the statement of financial position as at 30 June 2014, the statement of financial performance, statement of comprehensive income, statement of movements in equity and statement of cash flows for the year ended on that date and the notes to the financial statements that include accounting policies and other explanatory information; and

» the non-financial performance information of the Health Board and group that comprises the statement of service performance on pages 29 to 56, which includes outcomes.

UNMODIFIED OPINION ON THE FINANCIAL STATEMENTS

In our opinion the financial statements of the Health Board and group on pages 57 to 99:

» comply with generally accepted accounting practice in New Zealand; and

» fairly reflect the Health Board and group's:

» financial position as at 30 June 2014; and

» financial performance and cash flows for the year ended on that date.

Qualified opinion on the performance information because of limited control on information from thirdparty health providers.

REASON FOR OUR QUALIFIED OPINION

Some significant performance measures of the Health Board and group, (including some of the national health targets, and the corresponding district health Board sector averages used as comparators), rely on information from thirdparty health providers, such as primary health organisations. The Health Board and group's control over much of this information is limited, and there are no practical audit procedures to determine the effect of this limited control. For example, the primary care measure that includes advising smokers to quit relies on information from general practitioners that we are unable to independently test.

Our audit opinion on the performance information of the Health Board and group for the period ended 30 June 2013, which is reported as comparative information, was modified for the same reason.

QUALIFIED OPINION

In our opinion, except for the effect of the matters described in the "Reason for our qualified opinion" above, the performance information of the Health Board and group on pages 29 to 56 and page 98:

» complies with generally accepted accounting practice in New Zealand; and

» fairly reflects the Health Board's and group's service performance and outcomes for the year ended 30 June 2014, including for each class of outputs:

- the service performance compared with forecasts in the statement of forecast service performance at the start of the financial year; and
- the actual revenue and output expenses compared with the forecasts in the statement of forecast service performance at the start of the financial year.

Our audit was completed on 28 October 2014. This is the date at which our opinion is expressed.

The basis of our opinion is explained below. In addition, we outline the responsibilities of the Board and our responsibilities, and we explain our independence.

BASIS OF OPINION

We carried out our audit in accordance with the AuditorGeneral's Auditing Standards, which incorporate the International Standards on Auditing (New Zealand). Those standards require that we comply with ethical requirements and plan and carry out our audit to obtain reasonable assurance about whether the financial statements and performance information are free from material misstatement.

Material misstatements are differences or omissions of amounts and disclosures that, in our judgement, are likely to influence readers' overall understanding of the financial statements and performance information. We were unable to determine whether there are material misstatements in the performance information because the scope of our work was limited, as we referred to in our opinion.

An audit involves carrying out procedures to obtain audit evidence about the amounts and disclosures in the financial statements and performance information. The procedures selected depend on our judgement, including our assessment of risks of material misstatement of the financial statements and performance information, whether due to fraud or error. In making those risk assessments, we consider internal control relevant to the preparation of the Health Board and group's financial statements and performance information that fairly reflect the matters to which they relate. We consider internal control in order to design audit procedures that are appropriate in the circumstances but not for the purpose of expressing an opinion on the effectiveness of the Health Board and group's internal control.

OUR AUDIT OF THE FINANCIAL STATEMENTS INVOLVED EVALUATING:

- the appropriateness of accounting policies used and whether they have been consistently applied;
- the reasonableness of the significant accounting estimates and judgements made by the Board; and
- the adequacy of disclosures in, and overall presentation of, the financial statements.

OUR AUDIT OF THE NON-FINANCIAL PERFORMANCE INFORMATION INVOLVED EVALUATING:

- the appropriateness of the reported service performance within the Health Board and group's framework for reporting performance; and
- the adequacy of disclosures in, and overall presentation of, the non-financial performance information.

We did not examine every transaction, nor do we guarantee complete accuracy of the financial statements and performance information. Also we did not evaluate the security and controls over the electronic publication of the financial statements and performance information.

We have obtained all the information and explanations we have required about the financial statements. However, as referred to in our qualified opinion, we did not obtain all the information and explanations we required about the performance information of the Health Board and group. We believe we have obtained sufficient and appropriate audit evidence to provide a basis for our audit opinions.

RESPONSIBILITIES OF THE BOARD

The Board is responsible for preparing financial statements and performance information that:

- comply with generally accepted accounting practice in New Zealand;
- fairly reflect the Health Board and group's financial position, financial performance and cash flows; and
- fairly reflect the Health Board and group's service performance achievements and outcomes.

The Board is also responsible for such internal control as it determines is necessary to enable the preparation of financial statements and non-financial performance information that are free from material misstatement, whether due to fraud or error. The Board is also responsible for the publication of the financial statements and non-financial performance information, whether in printed or electronic form.

The Board's responsibilities arise from the New Zealand Public Health and Disability Act 2000 and the Crown Entities Act 2004.

RESPONSIBILITIES OF THE AUDITOR

We are responsible for expressing an independent opinion on the financial statements and performance information and reporting that opinion to you based on our audit. Our responsibility arises from section 15 of the Public Audit Act 2001 and the Crown Entities Act 2004.

INDEPENDENCE

When carrying out the audit, we followed the independence requirements of the AuditorGeneral, which incorporate the independence requirements of the External Reporting Board.

Other than the audit, we have no relationship with or interests in the Health Board or any of its subsidiaries.

John Mackey

Audit New Zealand

On behalf of the AuditorGeneral

Christchurch, New Zealand

Statement of Responsibility

The Board and management of Nelson Marlborough District Health Board (NMDHB) accept responsibility for the preparation of the Annual Financial Statements and the judgements used in them.

The Board and management of NMDHB accept responsibility for establishing and maintaining a system of internal control designed to provide reasonable assurance as to the integrity and reliability of financial reporting.

In the opinion of the Board and management of NMDHB the Annual Financial Statements for the twelve months ended 30 June 2014 fairly reflect the financial position and operations of NMDHB.

Jenny Black	Russell Wilson	Chris Fleming	Eric Sinclair
Board Chair	***Chair, Audit and Risk Committee***	***Chief Executive***	***GM Finance and Performance***

Statement of Service Performance

PREVENTION SERVICES

Output Class Description

Preventative health services promote and protect the health of the whole population, or identifiable sub-populations, and influence individual behaviours by targeting population-wide changes to physical and social environments to influence and support people to make healthier choices.

These services include:

- education programmes and services that raise awareness of risk behaviours and healthier options
- legislation, regulation and policy that protects the public from toxic environmental risks and communicable diseases
- population-based immunisation and screening programmes that support early intervention to maintain good health.

Funding and delivery of these services are the responsibility of many organisations across the district, including: the Ministry of Health; NMDHB Community Based Services Directorate Public Health Unit; primary care services and general practice; a number of non-government organisations; and local Government. A mix of public and private funding is used to provide these services.

Why Is This Output Class Significant For NMDHB?

These services support people to address any risk factors that contribute to long-term conditions development. They enable people to avoid, delay or reduce the impact of these conditions on their quality of life. High health need and at-risk population groups (low socio-economic Maori and Pacific) who are more likely to engage in risky behaviours and to live in environments less conducive to making healthier choices are targeted. Preventative services are our best opportunity to target improvements in the health of these high need populations to reduce inequalities in health status and improve population health outcomes. These services ensure that threats to the health of the community are detected early and prevented. These services also respond to emergency events such as pandemics or earthquakes.

What are the output class major sub-sets and how are they described?

- Health Promotion and Education Services: Health promotion has been defined by the World Health Organisation's 2005 Bangkok Charter for Health Promotion in a Globalized World as 'the process of enabling people to increase control over their health and its determinants, and thereby improve their health'. The primary means of health promotion occur through developing healthy public policy that addresses the prerequisites of health, such as income, housing, food security, employment, and quality working conditions. Health Education services inform people about health matters and support them to be healthy. Success is measured by greater awareness, engagement and the volume of programmes that support people to maintain wellness, and assist them to change personal behaviours.
- Statutory and Regulatory Services are services which sustainably manage environmental elements and risks in a way that supports people and communities to make healthier choices and maintain their health and safety. These services are frequently delivered by public health units and include effective quarantine and bio-security procedures, proper management of hazardous substances, assurance of safe drinking water, and compliance monitoring with liquor licensing and smoke environment legislation.
- Population Based Screening Services are services mostly funded and provided through the National Screening Unit that help to identify people at risk of illness earlier including breast screening, cervical cancer screening, newborn hearing testing, antenatal HIV screening, etc. The DHB's role is to encourage uptake, as indicated by high coverage rates.
- Immunisation Services are services which prevent the outbreak of vaccine-preventable diseases and unnecessary hospitalisations. The DHB works with primary care and allied health professionals to improve the provision of immunisations across all age groups both routinely and in response to specific risk. A

high coverage rate is indicative of a well-coordinated and successful approach to immunisation delivery for our region.

» Well Child Tamariki Ora Services are a screening, surveillance, education and support services offered to all New Zealand children and their family or whanau from birth to five years. It assists families and whanau to improve and protect their children's health. Services in our district are provided by Plunket, Maori Health Providers and the Public Health Service.

» Mental Health Promotion are services that promote a social and physical environment that enhances mental health and resiliency. These services promote mental wellbeing; raise knowledge of mental illness including recognition of early warning signs and availability of appropriate interventions; and reduce stigma and discrimination towards people who experience mental illness.

Outputs And Performance Measures 2013/14: Health Promotion And Education Services

Health promotion services work to develop public policy that addresses the prerequisites of health such as income, housing, food security, employment, and quality working conditions. Health Education services inform people about the risks and support them to be healthy. Success begins with awareness and engagement, reinforced by programmes that support people to maintain wellness or assist them to make healthier choice. Change is indicated by rates of positive or negative behaviours (such as smoking rates).[1]

MEASURES QUALITY (Q) – QUANTITY (V) – COVERAGE (C) – TIMELINESS (T)	NOTES	ACTUAL 2012/13	TARGET 2013/14	CURRENT NATIONAL AVERAGE	2013/14 ACHIEVED	COMMENTS ON 2013/14 PERFORMANCE
Number of submissions and Health Impact Assessments completed	V	5	5	n/a	9 submissions	**Achieved** Nine submissions were made in 2013/14 including local authority draft annual plans.
Proportion of hospitalised smokers who are provided with advice and support to quit in hospital settings	C	95%	≥95%	88% (Q1 2011/12)	95% (this is the quarter 4 2013/14 result which includes the data for the previous 12 months).	**Achieved** Maintenance of this level of achievement against the target has been challenging and takes a combined approach from clinical and support staff to deliver: staff education and support, feedback on results, auditing to ensure accurate data capture orientation and an on-going commitment to clinical best practice.
Proportion of enrolled patients who smoke & are seen in General Practice who are provided with advice and help to quit	C	48.14%	≥90%	32.9 (Dec 2011)	74.5% (this is the quarter 4 2013/14 result which includes the data for the previous 12 months).	**Not Achieved** Performance has increased from 48.14% in 2012/13. This target has a variety of different general practice settings and the large number of patients involved and is taking time to develop and embed the systems that enable achievement of the target. It involves education in clinical practice and utilising the systems for ensuring the activity is accurately recorded and collated to measure the achievement.
Proportion of babies are breast-fed (exclusive and full) in the district at three months of age	Q,C	63%	≥62%	57% (national target)	62%	**Achieved** Local breastfeeding rates remain constant.

1 Measures rated as Partially Achieved are within 10% of the target for 2013/14.

MEASURES QUALITY (Q) – QUANTITY (V) – COVERAGE (C) – TIMELINESS (T)	NOTES	ACTUAL 2012/13	TARGET 2013/14	CURRENT NATIONAL AVERAGE	2013/14 ACHIEVED	COMMENTS ON 2013/14 PERFORMANCE
Provision of a consistent, quality FVIP that achieves above the national benchmark score of 70 on the FVIP Evaluation Audit of hospital responsiveness for child abuse	Q	81%	≥85%	71%	91%	**Achieved** Self audit results provided to MOH as part of the Violence Intervention Programme reporting requirements. Score yet to be validated directly by Ministry of Health.
NMDHB provides a consistent, quality FVIP and achieves above the national benchmark score of 70 on the FVIP Evaluation Audit of hospital responsiveness for partner abuse.	Q	80%	≥81%	67%	82%	Achieved Self audit results provided to MOH as part of the Violence Intervention Programme reporting requirements. Score yet to be validated directly by Ministry of Health.

Outputs And Performance Measures 2013/14: Statutory Regulation

These services sustainably manage environments to support people and communities to make healthier choices and maintain health and safety. They include compliance monitoring with liquor licensing and smoke environment legislation, assurance of safe drinking water, proper management of hazardous substances and effective quarantine and bio-security procedures.

MEASURES QUALITY (Q) – QUANTITY (V) – COVERAGE (C) – TIMELINESS (T)	NOTES	ACTUAL 2012/13	TARGET 2013/14	2013/14 ACHIEVED	COMMENTS ON 2013/14 PERFORMANCE
Implement the Health (Drinking Water) Amendment Act 2007 by providing IANZ endorsed reports within 20 working days of assessments for Public Health Risk Management Plans (PHRMP's)	V	11	5-10	11	**Achieved** The processing of Water Safety Plans is dependent on the number submitted by utility providers, in line with the transition timeframes set by Parliament. Three new plans were assessed, with one not being approved due to inadequate risk identification.
Number of mosquito surveillance visits (weekly in summer and fortnightly in winter at Port Nelson [8 sites] and Port Marlborough [5 sites])	V	586	≥507	631 surveillance visits	**Achieved** There were no exotic species found during this period. 22 out of 631 samples taken were all identified as native species.
Controlled purchase operations (CPOs) to audit for sales of tobacco to people under 18 years	V, Q	89 premises	80-100 premises	61 premises.	**Not Achieved** During the reporting period the Ministry (Health) initiated changes to the manner in which Controlled Purchase Operations are undertaken. As a consequence fewer premises (61) where visited than was originally planned for. The new programme resulted in 12 sales of tobacco products to the 18 age group. This is a significant increase in sales and better reflects sales from retail premises to this age group. Prior to this change only one sale was recorded over a period of six years.

MEASURES QUALITY (Q) – QUANTITY (V) – COVERAGE (C) – TIMELINESS (T)	NOTES	ACTUAL 2012/13	TARGET 2013/14	2013/14 ACHIEVED	COMMENTS ON 2013/14 PERFORMANCE
Audits of retailers for compliance with the Smokefree Environments Act	V	141	≥80	115.	**Achieved** Changes to the Tobacco regulatory programme resulted in additional premises being visited.
CPOs to audit licensed premises for sales of alcohol to people under 18 years	V	60	≥80	172	**Achieved** From the 172 premises visited there have been 12 sales made to the 16 year old volunteer.
Percentage of reported communicable diseases followed up by Medical Officers of Health	Q	60%	≥80%	92%	**Achieved** A total 655 cases of communicable diseases were received of which 605 were investigated. The 50 that were not investigated relate to low risk Campylobacter cases which did not meet the criteria for investigation.

Outputs And Performance Measures 2013/14: Population Based Screening

These services are mostly funded and provided through the National Screening Unit and help to identify people at risk of illness and pick up conditions earlier. They include breast and cervical cancer screening and antenatal HIV screening. The DHB's role is to encourage uptake, as indicated by high coverage rates.

MEASURES QUALITY (Q) – QUANTITY (V) – COVERAGE (C) – TIMELINESS (T)	NOTES	ACTUAL 2012/13	TARGET 2013/14	CURRENT NATIONAL AVERAGE	2013/14 ACHIEVED	COMMENTS ON 2013/14 PERFORMANCE
Percentage of enrolled women aged 20-69 who have had a cervical screen at least once in the last three years	C	75.4% Marlborough 83.2% Nelson	≥75%	74.41% (Jun-11)	77.6% Marlborough 85.48% Nelson	**Achieved** Total as at 31 March 2014
Percentage of high needs enrolled women aged 20-69 who have had a cervical screen at least once in the last three years	C	68.8% Marlborough 79.5% Nelson	≥70%	66.56% (Jun-11)	72.17% Marlborough 80.99% Nelson	**Achieved** Total as at 31 March 2014
Percentage of high needs women aged 45-65 who have participated in the mammography screening programme within 2 years	C	72% Marlborough 77.8% Nelson	≥70%	62.8% (Jun-11)	72.43 % Marlborough 76.23% Nelson	**Achieved** Total as at 31 March 2014. The age range has now changed to 45-69 years.
Percentage of newborn hearing screening programme (consents for screening compared to live births)	C	99.5% (Oct 11-Mar 12)	≥62%	77.8%	95%	**Achieved** NMDHB continues to perform well to ensure babies are screened in our district. This is achieved through a combination of in-patient screening, outpatients' appointments and a drop-in service.
Percentage of newborn screening completed within 1 month of birth	Q, T	95.1%	≥95%	94.0%	95.1%	Achieved

Outputs And Performance Measures 2013/14: Immunisation Services

These services reduce the transmission and impact of vaccine-preventable diseases. The DHB works with primary care and allied health professionals to improve the provision of immunisations across all age groups both routinely and in response to specific risk. A high coverage rate is indicative of a well-coordinated and successful service

MEASURES QUALITY (Q) – QUANTITY (V) – COVERAGE (C) – TIMELINESS (T)	NOTES	ACTUAL 2012/13	TARGET 2013/14	CURRENT NATIONAL AVERAGE	2013/14 ACHIEVED	COMMENTS ON 2013/14 PERFORMANCE
Percentage of two-year-olds fully vaccinated	C	87%	≥95%	88%	88% over the 12 month period	**Not Achieved** Nelson Marlborough has difficulty in achieving this target. While we endeavour to have good systems and services in place to facilitate access to immunisation and thus high coverage, there are a significant number of parents in this district who choose not to immunise. For this 12 month period, the decline rate for immunisation was 8.5%. There was another 1.1% who opted-off the NIR (the information system that records the immunisations that individual receive), so that their immunisation status is unknown. From the 1,701 children eligible (i.e. turning two years in this period), 1,500 were fully immunised, 145 declined and 18 opted off, leaving 38 who were not fully immunised by the time they turned two.
Percentage of 8 month old children who have completed their scheduled immunisations	C	87%	≥90%[1]	n/a	90%	**Achieved**
Number of schools with year 7 & 8 students who are offered vaccination programmes	V	100%	≥100%	n/a	100%	**Achieved** All schools with Year 7 & 8 students were offered the vaccination programmes.
Over 65-year-olds vaccinated for seasonal influenza – Marlborough	C,Q	59%	≥60.52%	65.05%	64.45%	**Achieved**
Over 65-year-olds vaccinated for seasonal influenza – Nelson Bays	C,Q	67.2%	≥68.7%	65.05%	69.89%	**Achieved**

Outputs And Performance Measures 2013/14: Well Child Tamariki Ora Services

Work with Plunket as the national provider to ensure high coverage and quality of Well Child services in the district, in line with service specifications. Well Child services delivered locally by Public Health services and Maori Health providers. Public Health Services under the Community-Based Services Directorate will deliver B4 School Checks to all children in their fourth year of age.

MEASURES QUALITY (Q) – QUANTITY (V) – COVERAGE (C) – TIMELINESS (T)	NOTES	ACTUAL 2012/13	TARGET 2013/14	CURRENT NATIONAL AVERAGE	2013/14 ACHIEVED	COMMENTS ON 2013/14 PERFORMANCE
Number of Before (B4) School Checks	V	1,492	≥1,433	n/a	1,637	**Achieved**
Percentage of eligible children receiving Before (B4) School Checks	C	83%	≥80%	73.8%	102%	**Achieved**
Number of Before (B4) School Checks – high deprivation	V	140	≥114	n/a	113	**Partially Achieved**
Services delivered by providers in accordance with the Well Child Framework	Q	100%	100%	n/a	100%	**Achieved**

Outputs And Performance Measures 2013/14: Mental Health Promotion

The Children of Parents with Mental Illness service is targeted to intervene earlier and facilitate access to community, primary and specialist health supports. The service is aimed at building resilience and averting future adverse outcomes for infants, children and youth.

MEASURES QUALITY (Q) – QUANTITY (V) – COVERAGE (C) – TIMELINESS (T)	NOTES	ACTUAL 2012/13	TARGET 2013/14	2013/14 ACHIEVED	COMMENTS ON 2013/14 PERFORMANCE
Complete a service stocktake and gaps analysis of primary and community services available for youth in the district, in collaboration with local partners.	V	n/a new services)	Development of stocktake framework and completion of stocktake by 31 December 2013	Stocktake completed	**Achieved** The stocktake now provides an information base to assist planning and development of youth services. It remains a work in progress and can be updated as required.

Output Class Statement Of Financial Performance

$000s	2013-2014 ACTUAL	2013-2014 PLAN	VARIANCE
Revenue	**7448**	**7422**	**25**
Expenditure			
Personnel Costs	3419	3847	428
Outsourced services	128	135	8
Clinical Supplies	96	74	(22)
Infrastructure	777	661	(116)
Provider Payments	2320	1845	(475)
Total Expenditure	**6740**	**6563**	**(177)**
Net Surplus/(Loss)	**708**	**860**	**(152)**

EARLY DETECTION AND MANAGEMENT SERVICES

Output Class Description

Early detection and management services cover a broad scope and scale of services provided across the continuum of care activities to maintain, improve and restore people's health. These services include:

- detection of people at risk and with early disease
- more effective management and coordination of people with long-term conditions.

These services are by nature more generalist, usually accessible from multiple providers and a number of different locations. Providers include:

- general practice services
- primary and community services
- personal and mental health services
- Maori and Pacific health services
- pharmacy services
- diagnostic imaging services
- diagnostic laboratory services
- children and youth oral health and dental services.

A significant proportion of these services are demand driven, such as pharmacy, community radiology and diagnostic laboratory services. These services are provided with a mix of public and private funding and may include co-payments for general practice and pharmacy services.

Why is this Output Class significant for NMDHB?

New Zealand is experiencing an increasing prevalence rate of long-term conditions such as diabetes and cardiovascular disease, and some population groups suffer from these conditions more than others, for example, Maori and Pacific people, older people and those on lower incomes. The health system is also experiencing increasing demand for acute and urgent care services. For NMDHB cancer, respiratory disease, chronic pain and dementia are significant long-term conditions that are prevalent locally. Early detection and management services based in the community deliver earlier identification of risk, provide opportunity to intervene in less invasive and more cost-effective ways, reduce the burden of long-term conditions through supported self- management (avoidance of complications, acute illness and crises). These services deliver coordination of care, supporting people to maintain good health.

Below is the description of the sub-sets of services that make up this output class:

- **PRIMARY HEALTH CARE (GP)**
  Services are services offered in local community settings by a primary care team including general practitioners (GPs), registered nurses, nurse practitioners and other primary health care professionals aimed at improving, maintaining or restoring people's health. High levels of enrolment with general practice are indicative of engagement, accessibility and responsiveness of primary care services.
- **ORAL HEALTH SERVICES**
  are services provided to assist people in maintaining healthy teeth and oral tissues and are provided by approved registered oral health professionals. High enrolments are indicative of engagement, while more timely examination and treatment of children will indicate a well functioning and efficient approach to delivery.

» **PROGRAMMES OF INTEGRATED CARE**

Components of programmes integrated care[2] include:

- Self-management support and patient education: Self-management support involves collaboratively helping patients and their families acquire the skills and knowledge to manage their own illness, providing self-management tools and routinely assessing problems and accomplishments. Education is giving the patients information (materials and/or instructions) regarding their condition and possible management.
- Clinical follow-up: This means monitoring the patient after or during treatment on a close regular base. This is often done by a nurse case manager who uses a phone, mailings, or visits. Clinical follow-up can be seen as part of self-management support.
- Case management: This means explicit allocation of coordination tasks to an appointed individual (a case manager) or a small team who may or may not be responsible for the direct provision of care. The case manager or team takes responsibility for guiding the patient through the complex care process in the most efficient, effective and acceptable way.
- A multidisciplinary patient care team: This is composed of a group of professionals who communicate with each other regularly about the care of a defined group of patients and participate in that care.
- Multidisciplinary clinical pathway: Clinical pathways or integrated care pathways are structured multidisciplinary care plans which detail essential steps in the care of patients with a specific clinical problem and describe the patient's expected clinical course. Clinical pathways should be derived from evidence-based guidelines translated into practice.
- Feedback, reminders, and education for professionals: The aim of feedback, reminders, and education is to provide health care providers with information regarding appropriate care for patients. This information can come from clinical pathways, medical records, computerised databases, patients, or audits by colleagues. Feedback is given after the consultation; education is given before consultation; reminders are given before or during consultation.
- Additional requirements: (i) Supportive clinical information system; (ii) specialised clinics or centres; (iii) shared mission on integrated care; (iv) leaders with a clear vision on integrated care; (v) finances for implementation and maintenance; (vi) management commitment and support; (vii) patients capable and motivated for self-management; (viii) culture of quality improvement.

» **PHARMACY SERVICES**

are services aligned to requirements of the pharmaceutical schedule, including provision and dispensing of medicines. Pharmaceuticals are demand driven and we are likely to see an increased dispensing of pharmaceutical items, as more people engage with health services. To improve performance, NMDHB will target medication management for people on multiple medications to reduce potential negative interactive effects.

» **COMMUNITY REFERRED TESTING AND DIAGNOSTIC IMAGING SERVICES**

are services[3] to which a health professional may refer a person to help diagnose a health condition, or as part of treatment. They are provided by personnel such as laboratory technicians, medical radiation technologists and nurses. These services are demand driven and are likely to increase as more people engage with health services and respond to health promotion messages about early diagnosis. To improve performance, we will target an increase in the number of community referred radiological images (MRI, CT, Coronary angiography, Ultrasound), as an indication of improved primary care access to diagnostics, without the need for a hospital appointment.

» **INFECTION CONTROL**

are services that are committed to prevention of infections and occupational exposures throughout the healthcare continuum. The programme manages and minimises the infection risk by incorporating measures/interventions that are required to prevent pathogen transfer between patients, staff and visitors and in safe-guarding patients from developing infections due to, or resulting from, medical interventions.

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2 See "Integrated Care Programmes for Chronically Ill patients: a review of systematic reviews. Marielle Ouwens, Hub Wollersheim, Rosella Hermens, Marlies Hulscher Richard Grol. Int J Qual Health Care (2005) 17 (2): 141-146. doi: 10.1093/intqhc/mzi016 First published online: January 21, 2005

3 Laboratory, imaging procedures, cardiology/physiological procedures, audiology services, neurology services, endocrinology services

» **Primary and Mental Health Services**

are services that are delivered in a primary care setting for the assessment, treatment and when needed the ongoing management of people with mild to moderate mental health and/or addiction issues. This includes promotion, prevention, early intervention and ongoing treatment.

Outputs And Performance Measures 2013/14: Primary Health Care (GP) Services

These services are offered in local community settings by teams of general practitioners (GPs), registered nurses, nurse practitioners and other primary health care professionals, aimed at improving, maintaining or restoring people's health. High levels of enrolment with general practice are indicative of engagement, accessibility and responsiveness of primary care services.

Keep more people well by:

» intervening early to detect, manage and treat existing health conditions

» better education and advice so people can manage their own health

» reaching those at risk of developing long-term or acute conditions.

MEASURES QUALITY (Q) – QUANTITY (V) – COVERAGE (C) – TIMELINESS (T)	NOTES	ACTUAL 2012/13	TARGET 2013/14	CURRENT NATIONAL AVERAGE	2013/14 ACHIEVED	COMMENTS ON 2013/14 PERFORMANCE
Percentage of people in the district enrolled with a PHO - Nelson	C	99%	≥ 99%	96%	99%	**Achieved**
Percentage of people in the district enrolled with a PHO - Marlborough	C	93% approx	>96%	96%	98%	**Achieved**
Percentage of people with diabetes who have had Annual Reviews	C	73.82%	≥90%	N/A	80.10%	**Not Achieved**
Percentage of the eligible adult population will have their cardiovascular disease (CVD) risk assessed in the last five year by 30 June 2014.	C	57.3%	≥90%	78.2%	77.8%	**Not Achieved**
Number of people enrolled in the Care Plus programme each quarter:	V	91% (7476)	≥85% of available places	N/A	96%	**Achieved** This is the average over the four quarters of 2013/14.
Ambulatory Sensitive Hospitalisation rates for children age 0 – 4 are reduced – Total Population	Q[2]	92%	108%	100%	79%	**Achieved** Ambulatory Sensitive Hospitalisation rates for the year to end March 2014 for Other Ethnicities have decreased by 5%. Rates for Maori have increased by 33%, however NMDHB has formally questioned the data supplied.

MEASURES QUALITY (Q) – QUANTITY (V) – COVERAGE (C) – TIMELINESS (T)	NOTES	ACTUAL 2012/13	TARGET 2013/14	CURRENT NATIONAL AVERAGE	2013/14 ACHIEVED	COMMENTS ON 2013/14 PERFORMANCE
Percentage of newborns enrolled with a PHO by four weeks	T	60%	≥95%	N/A	Nelson Bays Primary Health: 92%; Kimi Hauora Wairau: 51% enrolled at 4 weeks for calendar year 2013.	**Not Achieved** The newborn enrolment figure is a relatively new measure and enrolment processes are still being refined.

Outputs And Performance Measures 2013/14: Oral Health Services

These services are provided by registered oral health professionals to assist people in maintaining healthy teeth and gums. High enrolments are indicative of engagement, while more timely examination and treatment indicates a well-functioning and efficient service.

We are influencing the oral health status of young children through:

- Implementation of the new model of care for primary school and pre-school children through the Community Oral Health Hubs, including
- Targeting children and adolescents living in disadvantaged areas with oral health promotion programmes
- Work with Well Child Tamariki Ora providers to increase the enrolment of preschool children with the service

We maintain utilisation of dental service for adolescents through maintaining access to services and ensuring dental service providers operate effective recall systems. We are improving access to dental services for low income adults.

MEASURES QUALITY (Q) – QUANTITY (V) – COVERAGE (C) – TIMELINESS (T)	NOTES	ACTUAL 2012/13	TARGET 2013/14	CURRENT NATIONAL AVERAGE	2013/14 ACHIEVED	COMMENTS ON 2013/14 PERFORMANCE
Number of children under five enrolled in DHB funded dental services	C	5054	2012 ≥ 5000 2013 ≥ 5,780 2014 ≥ 5,800	Not available	6,103	**Achieved** This is an increase on the 5,054 children enrolled in 2012.
Proportion of children caries free at 5 years of age – Maori & Total	Q	40% Maori 64% Total	2012 ≥65% 2013 ≥ 65% 2014 ≥ 70%	57% (2010)	55%	**Not Achieved** There has been a 2% decline in the proportion of children carries free at five years.
Decayed, Missing, Filled, Teeth (DMFT) at year 8 (around age 12 years) – Maori & Total	Q	1.23 Maori 0.92 Total	2013 ≤ 1:10 2014 ≤ 1:10 2014 ≤ 1.00	1.89	1.00	**Achieved** A new model of care introduced in 2011 focusing on prevention and engaging whanau and caregivers in their children's oral health is starting to show improved results. In 2013 the proportion of DMFT at year 8 was higher at 1.23.

MEASURES QUALITY (Q) – QUANTITY (V) – COVERAGE (C) – TIMELINESS (T)	NOTES	ACTUAL 2012/13	TARGET 2013/14	CURRENT NATIONAL AVERAGE	2013/14 ACHIEVED	COMMENTS ON 2013/14 PERFORMANCE
Utilisation of adolescent oral health services	C	85.2%	2012 ≥ 85% 2013 ≥ 85% 2014 ≥ 85%	68.3%	85.3%	**Achieved** There was a continuation of the excellent performance achieved in 2013. Only three DHBs scored above 80% utilisation, with MDHB ranking second in NZ overall at 85.3%.

Outputs And Performance Measures 2013/14: Primary and Community Programmes of Care

These services are targeted at people with high health need due to long-term conditions and aim to reduce deterioration, crises and complications. Success is demonstrated through identification of need, regular monitoring and outcomes that demonstrate successful management of conditions. A focus on early intervention strategies and additional services available in the community will help to reduce the need for hospital appointments. The services provide:

» community programmes that support keeping people well and address inequalities

» targeted interventions for people to support areas of key inequality such as clinical interventions for people with asthma and other respiratory conditions, and podiatry services.

MEASURES QUALITY (Q) – QUANTITY (V) – COVERAGE (C) – TIMELINESS (T)	NOTES	ACTUAL 2012/13	TARGET 2013/14	CURRENT NATIONAL AVERAGE	2013/14 ACHIEVED	COMMENTS ON 2013/14 PERFORMANCE
Impacts are measured by maintaining our Ambulatory Sensitive Hospitalisation (ASH) indirectly standardised discharge ratio (ISDR) for asthma acute admissions per annum	V[3]	ASH rates ranged from 46% Maori (45-64 years) to 131% Non-Maori (0-4 years)	<100	<100	ASH rates ranged from 53% Other (45-64 years) to165% Maori (45-64 years). The ASH rate per 100,000 of population has declined for Other Ethnicities 0-4 years and 0-74 years, and increased for Other 45-64 years.	**Partially Achieved** ASH rates per 100,000 for Maori have all increased by factor of 1.5 to 2.2. NMDHB has formally questioned the data supplied.
Number of patients receiving asthma/ COPD services – Nelson & Marlborough	V	362 Nelson 87 Marlborough	≥443 Nelson ≥156 Marlborough	n/a	381 Nelson 121 Marlborough	**Not Achieved** Service delivery was higher than in 2012/13 but did not reach the higher forecast level for 2013/14.

MEASURES QUALITY (Q) – QUANTITY (V) – COVERAGE (C) – TIMELINESS (T)	NOTES	ACTUAL 2012/13	TARGET 2013/14	CURRENT NATIONAL AVERAGE	2013/14 ACHIEVED	COMMENTS ON 2013/14 PERFORMANCE
Number of patients receiving podiatry services[4] - Nelson & Marlborough	V	2,341 Nelson 1,009 Marlborough	≥2,400 Nelson ≥1,526 Marlborough	n/a	2,455 Nelson 1,066 Marlborough	**Partially Achieved** The target was met for Nelson. Delivery for Marlborough was just above the 2012/13 level.
Number of patients receiving Non-Malignant Pain Services9 – Nelson & Marlborough	V	n/a (new services)	≥200 Nelson ≥100 Marlborough	n/a	115 Nelson, 121 Marlborough	**Partially Achieved** This is a new service. Delivery was lower than expected for Nelson and above the target for Marlborough.

Outputs And Performance Measures 2013/14: Community Pharmacy Services

These services include provision and dispensing of medicines and are demand-driven. As long-term conditions become more prevalent, we are likely to see an increased dispensing of pharmaceutical items. To improve service quality we will introduce medication management for people on multiple medications to reduce potential negative interactive effects. We are:

- implementing safe and effective pharmacy services across settings of care (hospital and community) assisted by the Rutherford Performance Programme.
- implementing the first phase of the new community pharmacy service model
- working with PHO and NMDHB hospital prescribers on chronic non-malignant pain pharmacological best practice approaches.

MEASURES QUALITY (Q) – QUANTITY (V) – COVERAGE (C) – TIMELINESS (T)	NOTES	ACTUAL 2012/13	TARGET 2013/14	CURRENT NATIONAL AVERAGE	2013/14 ACHIEVED	COMMENTS ON 2013/14 PERFORMANCE
Percentage of patients whose medicines are reconciled within 24 hours of admission, transfer or discharge	V,Q	27%	≥40%	n/a	27.1%	**Not Achieved**
Total number of dispensed items	V	2,125,134	≥1,901,106	n/a	2,120,482	Achievement is demand driven
Percentage of pharmacies on new contract	V[5]	100%	100%	n/a	100%	**Achieved**
Percentage of pharmacies offering new community pharmacist long-term condition service	C[6]	100%	100%	n/a	100%	**Achieved**

MEASURES QUALITY (Q) – QUANTITY (V) – COVERAGE (C) – TIMELINESS (T)	NOTES	ACTUAL 2012/13	TARGET 2013/14	CURRENT NATIONAL AVERAGE	2013/14 ACHIEVED	COMMENTS ON 2013/14 PERFORMANCE
Average number of adverse events (ADE) each quarter which may cause patient harm	Q	Unable to report on this measure in 2012/13	<20	n/a	150	**Not Achieved** This is estimated from pharmacy and RiskPro pharmacy system. The DHB's risk improvement strategy now involves increasing the number of reports for both near misses, possible and actual harms to inform work on harm reduction.
Percentage reduction in community pharmaceutical costs	Q	2.7 %	<3%	n/a	1.5%	**Achieved** This is the change in community pharmacy expenditure excluding non-community pharmaceutical deductions from rebates.

Outputs And Performance Measures 2013/14: Infection Control

These services:

- minimise and manage the infection risks by incorporating measures and interventions required to prevent pathogen transfer between patients, staff and visitors
- monitor and refine systems used to manage the infection risks within NMDHB as per NZS 8134:2008
- safeguard patients from developing infections due to, or resulting from medical interventions
- participate in three national programmes including hand hygiene, central line associated blood stream infections, surgical site infection reduction

MEASURES QUALITY (Q) – QUANTITY (V) – COVERAGE (C) – TIMELINESS (T)	NOTES	ACTUAL 2012/13	TARGET 2013/14	CURRENT NATIONAL AVERAGE	2013/14 ACHIEVED	COMMENTS ON 2013/14 PERFORMANCE
Number of norovirus, and/or methicillin resistant staphylococcus aureus outbreaks	Q	1	0	n/a	0	**Achieved**
Episodes of patient infection involving two or more patients with the same micro-organism, during the same time period and linked by location or procedure	Q	0	<1	n/a	0	**Achieved**
Positive blood cultures in inpatients who have been in hospital for more than 48 hours (not present or incubating at admission) or related to a hospital health-care associated device or procedure	Q	16	0	n/a	18	**Not Achieved** Positive blood cultures in inpatients related to hospital health care occurred at a level similar to 2012/13.

MEASURES QUALITY (Q) – QUANTITY (V) – COVERAGE (C) – TIMELINESS (T)	NOTES	ACTUAL 2012/13	TARGET 2013/14	CURRENT NATIONAL AVERAGE	2013/14 ACHIEVED	COMMENTS ON 2013/14 PERFORMANCE
Percentage of wounds that develop symptoms, signs and microbiological evidence of infection within 30 days of selected clean surgical procedures	Q	1.4%	<4%	n/a	1.7%	**Achieved** Hip and knee prostheses only, as per national Surgical Site Infection Improvement programme.
Hand hygiene compliance rates	Q	n/a	≥70%	n/a	69.7%	**Partially Achieved** Results assessed by the national hand hygiene programme.

Outputs And Performance Measures 2013/14: Primary Mental Health

These services are targeted to those general practice patients with mild to moderate mental health problems/ symptomology. Target populations are Maori, Pacific and lower socio economic incomes. A range of services are provided including extended general practice consultations, packages of care, brief intervention clinical services and an anxiety disorder programme. Outcomes expected are improved access and flow through community, primary and specialist mental health services; and improved mental health wellbeing.

MEASURES QUALITY (Q) – QUANTITY (V) – COVERAGE (C) – TIMELINESS (T)	NOTES	ACTUAL 2012/13	TARGET 2013/14	CURRENT NATIONAL AVERAGE	2013/14 ACHIEVED	COMMENTS ON 2013/14 PERFORMANCE
Number of Extended General Practice Consultations and Packages of Care available.	V	1,567	≥933	n/a	2,642 extended GP consults were provided.	**Achieved** Performance in 2013/14 for one of the PHOs includes some follow-up consultations (within the funded volume price) and also some funded through carried over funds from 2012/13
Average PHQ -9[7] reductions	Q	9.5 points	7.5 points	n/a	4.0 Nelson 9.2 Marlborough to give an average across the district of 6.6 points in reducing the severity of depression.	**Partially Achieved**
Extend Single Point of Entry (SPOE) to Marlborough and to child and youth referrals	T	n/a	Extend services by June 2014	n/a	Commenced but to be completed in 2014/15.	**Not Achieved**
Establishment of youth liaison position	Q	n/a	By September 2013		Position filled by due date.	**Achieved**

MEASURES QUALITY (Q) – QUANTITY (V) – COVERAGE (C) – TIMELINESS (T)	NOTES	ACTUAL 2012/13	TARGET 2013/14	CURRENT NATIONAL AVERAGE	2013/14 ACHIEVED	COMMENTS ON 2013/14 PERFORMANCE
Review rural outreach services	C	n/a	By 31 March 2014		Commenced but to be completed in 2014/15.	**Not Achieved**
Explore viability of 'watchhouse' model (basing a crisis person with Police)	T	n/a	Briefing paper by 30 September 2013		This was explored and determined not to be viable.	**Not Achieved**

Outputs And Performance Measures 2013/14: Community Referred Testing and Diagnostics

These are services to which a health professional may refer a person to help diagnose a health condition, or as part of treatment. They are provided by personnel such as laboratory technicians, medical radiation technologists and nurses. To improve performance, we will target improved primary care access to imaging diagnostics to improve clinical referral processes and decision making.

We are further maximising utilisation of diagnostic tests and procedures to ensure early detection and diagnosis of a patient condition and to assist effective assessment and treatment of a patient condition under treatment.

MEASURES QUALITY (Q) – QUANTITY (V) – COVERAGE (C) – TIMELINESS (T)	NOTES	ACTUAL 2012/13	TARGET 2013/14	CURRENT NATIONAL AVERAGE	2013/14 ACHIEVED	COMMENTS ON 2013/14 PERFORMANCE
Number of medical laboratory diagnostic tests	V	1,245,666	≥1,208,128	n/a	1,091,335	Achievement is demand driven This service is demand driven. Improved data procedures have resulted in lower test volumes.
Number Medical Imaging examinations	V	89,305	≥91,086	n/a	87,087	**Partially Achieved**
Number Cardiac procedures	V	1,228	≥899	n/a	1,078	**Achieved**
Number of respiratory procedures	V	180	≥180	n/a	249	**Achieved** Increased volumes as a result of the appointment of a respiratory physician.
Number of Audiology procedures	V	2,630	≥3,303	n/a	3,019	**Not Achieved** This includes community referred audiology and hearing aid assessments which is an increase of 389 procedures compared to 2012/13.

MEASURES QUALITY (Q) – QUANTITY (V) – COVERAGE (C) – TIMELINESS (T)	NOTES	ACTUAL 2012/13	TARGET 2013/14	CURRENT NATIONAL AVERAGE	2013/14 ACHIEVED	COMMENTS ON 2013/14 PERFORMANCE
Percentage of facilities with TELARC accreditation where applicable	Q	100%	100%	n/a	100%	**Achieved** NMDHB contracted laboratories meet the accepted standard for laboratories: ISO 15189. The reference to TELARC will be amended.
Percentage of urgent tests completed within 3 hours on receipt of sample at the lab	T	85%+	≥90%	n/a	90% +	**Achieved**
Reduce the days for availability of histology results - community	T	4 days	≤4 days	n/a	4 days	**Achieved**
Reduce the days for availability of histology results – hospital	T	3 days	≤3 days	n/a	3 days	**Achieved**
Percentage of routine laboratory test results available to referrers within 48 hours from time of receipt	C	88%+	≥85%	n/a	100%	**Achieved** This is for blood results only.
Percentage of Medical Imaging reports meeting 14-day-availability to referrer	T	95%	100%	n/a	100%	**Achieved** This is for in-patients.
Percentage of patients waiting time target for Medical Imaging procedures - urgent	T	100% within 24 hours	≥98% within 24 hours	n/a	100%	**Achieved** This is for in-patients.
Percentage of patients waiting time target for Medical Imaging procedures – semi-urgent	T	100% within 14 days	≥98% within 14 days	n/a	100%	**Achieved** This is for in-patients.
Percentage of patients waiting time target for Medical Imaging procedures - routine	T	100% within 14 days and above	≥99% within 14 days and above	n/a	100%	**Achieved** This is for in-patients.

Output Class Statement Of Financial Performance

$000s	2013-2014 ACTUAL	2013-2014 PLAN	VARIANCE
Revenue	**111,870**	**111,200**	**670**
Expenditure			
Personnel Costs	20,444	20,972	528
Outsourced services	1,698	1,809	111
Clinical Supplies	1,064	1,140	76
Infrastructure	6,343	6,644	300
Provider Payments	81,467	80,632	(835)
Total Expenditure	**111,016**	**111,197**	**181**
Net Surplus/(Loss)	**854**	**2**	**851**

INTENSIVE ASSESSMENT AND TREATMENT SERVICES

Output Class Description

Intensive assessment and treatment services are services that are complex and provided by specialists and other health care professionals working closely together in multi- and interdisciplinary teams. These services are therefore usually (but not always) provided in hospital settings that enable the co-location of clinical expertise and specialist equipment. These services include ambulatory services, inpatient and outpatient services, and emergency or urgent care services. As the local provider of hospital and specialist services, NMDHB provides an extensive range of intensive treatment and complex specialist services to our population. NMDHB also funds some tertiary and quaternary intensive assessment and treatment services for our population provided by other DHBs, private hospitals and private providers. A proportion of these services are driven by demand, such as unplanned (acute) and maternity services. However, others are planned (elective) services for which access is determined by capability, capacity, resources, clinical triage, national service coverage agreements and treatment thresholds.

Why Is This Output Class Significant For NMDHB?

Equitable timely access to intensive assessment and treatment can significantly improve people's quality of life, either through early intervention (i.e. removal of an obstructed gallbladder so that the patients does not have repeat attacks of abdominal pain/ colic, increased risk of cancer and/or infection) or through corrective action (i.e. major joint replacements to relieve pain and improve activity). Flexible and responsive assessment and treatment services can also support improvements across the whole system, enabling people to be supported in the community with confidence that complex intervention will be available when needed. It would then be expected that our population is able to establish greater lifestyle stability, based on improved public confidence in the health system and utilisation overall. As an owner and provider of these services, the DHB is also concerned with the quality of the services being provided. Adverse events in hospital, as well as causing harm to patients, drive unnecessary costs and redirect resources away from other services. Quality improvement in service delivery, systems and processes will improve patient safety, reduce the number of events causing injury, and provide improved outcomes for people in our services. Government has set clear expectations for the delivery of increased elective surgical volumes, a reduction in waiting times for treatments and increased clinical leadership to improve the quality of care being delivered. The changes being made to meet Government expectations are providing unique opportunities to introduce innovative clinically led service delivery models and improve productivity within our hospital services.

Description of the sub-sets of services that make up this output class:

» Inpatient Planned and Unplanned Services are services that include:

- **PLANNED (ELECTIVE) SERVICES** are services for people who do not need immediate hospital treatment and are 'booked' services. This includes elective surgery, but also non-medical interventions (such as coronary angioplasty) and specialist assessments (either first assessments, follow-ups or preadmission assessments). National Elective Services Patient Flow Indicators (ESPIs) are indicative of a successful and responsive service, addressing increasing needs and matching commitments to capacity.

- **UNPLANNED (ACUTE) SERVICES** are services for illnesses that have an abrupt onset and are often of short duration and rapidly progressive, creating an urgent need of care (nb: they may or may not lead to a hospital admission). Hospital-based acute services include emergency departments, short-stay acute assessments and intensive care services. Performance against clinical triage guidelines is used to demonstrate the capacity and responsiveness of the system. Productivity measures such as length of stay rates are balanced with outcome measures such as readmission rates to indicate the quality of service provision.

- **SPECIALIST MENTAL HEALTH SERVICES** are services for people who are most severely affected by mental illness or addictions and include assessment, diagnosis, treatment and rehabilitation, as well as crisis response when needed, and as required under the Mental Health Act. Currently the expectation established in the National Mental Health Strategy is that specialist services (including psychiatric disability services) will be available to 3% of the population. Utilisation rates will be monitored across age groups and ethnicities to ensure service levels are maintained and to demonstrate responsiveness.

» **MATERNITY SERVICES** are services provided to women and their families through pre-conception, pregnancy, childbirth and for the first months of a baby's life. These services are provided in home, community and hospital settings by a range of health professionals, including midwives, GPs and obstetricians and include: specialist obstetric, lactation, anaesthetic, paediatric and radiology services. We will monitor volumes in this area to determine access and responsiveness of services.

» **SPECIALIST ASSESSMENT, TREATMENT AND REHABILITATION SERVICES** are services provided to people who experience disability or age-related disorders to restore people's functional ability and enable them to live as independently as possible. Services are delivered in specialist inpatient units, outpatient clinics and also in home and work environments. Specialist geriatric and allied health expertise and advice is also provided to general practitioners, home and community care providers, residential care facilities and voluntary groups. An increase in the rate of people discharged home with support, rather than to residential care or hospital environment (where appropriate) will be indicative of success and of the responsiveness of services.

Outputs And Performance Measures 2013/14: Inpatient Planned (A – Elective) And Unplanned (B – Acute) Services Including Mental Health

a) These are services for people who do not need immediate hospital treatment and are 'booked' or 'arranged' services. This includes elective surgery, but also non-surgical interventions and specialist assessments.

b) These are services for illnesses that have an abrupt onset, are often of short duration and rapidly progressive, for which the need for care is urgent. Hospital based acute services include emergency departments, short-stay acute assessments and intensive care services. There are also a number of community-based acute demand programmes and packages of care unique to Nelson Marlborough, established to reduce acute demand.

Measures: Quality (Q) – Quantity (V) – Coverage (C) – Timeliness (T)

A - PATIENT SAFETY	NOTES	ACTUAL 2012/13	TARGET 2013/14	CURRENT NATIONAL AVERAGE	2013/14 ACHIEVED	COMMENTS ON 2013/14 PERFORMANCE
Recommendations on NMDHB Serious and Sentinel Events are implemented within agreed timeframes	Q	100%	100%	N/A	100%	**Achieved** New system in place that ensures all serious event recommendations are documented and allocated to a specific clinical leader to implement
Patient Complaints: Number of complaints to NMDHB for the 12 months 1 July to 30 June:	Q	358	≤325	N/A	374	**Not Achieved** NMDHB has implemented a new electronic system to monitor complaints monthly in a system with consistent groupings. This will provide good trend data for 2014/15 planning.
Complaints to NMDHB closed within 20 working days:	T	87%	100%	N/A	84%	**Not Achieved** New systems in place with a goal of increasing consistent performance to over 90% as a first step in reaching the annual plan target.
Health and Disability Commissioner complaints that results in a finding of breach of the Code of Rights	Q	1	0	N/A	1	**Not Achieved** This relates to a historical complaint which is over three years old.
B – SCHEDULED SERVICES (INPATIENTS AND OUTPATIENTS)	**NOTES**	**ACTUAL 2012/13**	**TARGET 2013/14**	**CURRENT NATIONAL AVERAGE**		
Total elective caseweight (CWD) discharges provided	V[8]	9,092	≥7,392[9]	N/A	8,400	**Achieved**
Total number of elective surgical discharges provided	V	6,054	≥6,029[10]	N/A	6,197	**Achieved**
Elective and arranged surgery is undertaken on a day case basis	Q[11]	66.97%	≥60.5%	56%	67.1%	**Achieved**
People receive their elective and arranged surgery on the day of admission	Q[12]	96.4%	≥97%	80%	96.62%	**Partially Achieved**
Average elective and arranged inpatient length of stay (days) is maintained	Q[13]	2.84	≤3.0	4.9	2.86	**Achieved**
ESPI overall flow indicators are met	T	100%	≥100%	N/A	100%	**Achieved** Confirmed in MoH July 2014 report.

A - PATIENT SAFETY	NOTES	ACTUAL 2012/13	TARGET 2013/14	CURRENT NATIONAL AVERAGE	2013/14 ACHIEVED	COMMENTS ON 2013/14 PERFORMANCE
C - UNSCHEDULED SERVICES (INPATIENTS AND OUTPATIENTS)	**NOTES**	**ACTUAL 2012/13**	**TARGET 2013/14**	**CURRENT NATIONAL AVERAGE**		
Total number of people presenting at hospital Emergency Departments (ED)	V	45,419	<35,000	N/A	47,802	**Not Achieved** We continue to monitor the ED performance by site, and a focus is on reducing ED presentations as it is clear there remains excessive use of ED in Wairau based on population statistics.
People are assessed, treated or discharged from ED under six hours	T	96.53%	≥95%	N/A	95.82%	**Achieved**
GP practices provide patients access to telephone triage outside business hours	C	100%	100%	N/A	100%	**Achieved**
Total acute inpatient average length of stay (days) is maintained	Q[14]	3.48	≤3.29	4.09	3.50	**Not Achieved** While the target was not met NMDHB has the fourth lowest acute inpatient length of stay rate in New Zealand in quarter 4, 2013/14. NMDHB's acute length of stay is well below the national average.
People receive radiation oncology treatment within 4 weeks of decision to treat	T	100%	100%	N/A	100%	**Achieved** All patients were treated within required timeframes.
People receive medical oncology treatment within 4 weeks of decision to treat	T	90%	100%	N/A	100%	**Achieved** Patients were treated within the four week timeframe.
Acute readmissions rate to hospital	Q[15]	9.74%	≤6.3%	N/A	6.8%	**Not Achieved** While the target was not met NMDHB has the sixth lowest acute readmissions rate to hospital in New Zealand in quarter 4, 2013/14.
Acute readmissions rate to hospital (over 75 years)	Q[16]	13.69%	≤8.63%	N/A	9.4%	**Not Achieved** While the target was not met NMDHB has the sixth lowest acute readmissions rate to hospital for people over 75 years min New Zealand in quarter 4, 2013/14.

Outputs And Performance Measures 2013/14: Maternity Services

These services are provided to women and their families through pre-conception, pregnancy, childbirth and for the first months of a baby's life. These services are provided in home, community and hospital settings by a range of health professionals, including midwives, GPs and obstetricians and include specialist obstetric, lactation, anaesthetic, paediatric and radiology services. We will monitor volumes in this area to determine access and responsiveness of services.

MEASURES QUALITY (Q) – QUANTITY (V) – COVERAGE (C) – TIMELINESS (T)	NOTES	ACTUAL 2012/13	TARGET 2013/14	CURRENT NATIONAL AVERAGE	2013/14 ACHIEVED	COMMENTS ON 2013/14 PERFORMANCE
Total number of maternity deliveries in the NMDHB district	V[17]	1,413	≥1600	N/A	1,544	Achievement is demand driven All the births registered in the Tasman, Nelson and Marlborough district in the 2013 calendar year.
Proportion of total deliveries, made in primary birthing units	Q[18]	4.3%	≥6.2%	N/A	Overall in the NMDHB region 7% of births occurred in primary unit or at home in 2013.	**Achieved**
Average post natal length of stay (days) is maintained	V[19]	2.02 days	≥3.00	N/A	Nelson 2.1 days, Wairau 2.4 days	**Not Achieved**
Caesarean rate	Q	29.4%	≤28%	N/A	31.37%	**Not Achieved** The Caesarean rate was slightly above target, but is unpredictable, being determined by clinical need. Increasing maternal morbidities are contributing to increased caesarean section rate.
Exclusive breast feeding at discharge from facility	Q	Approx 84% combined rate (80% Nelson, 90% Marlborough)	≥86%	N/A	86.5%	**Achieved**
Neonatal inpatients DRGs	V[20]	417	≥430	N/A	395	Achievement is demand driven
Perinatal infant mortality rate (per 1,000 births)	Q[21]	6.03 in 2011	<7.79	10.7	7.92(2007-12)	**Partially Achieved** NMDHB has the lowest perinatal related mortality rate in NZ. These are the latest results for perinatal infant mortality.
Maternal mortality rate (per 100,000 maternities)	Q[22]	0	0	14.7 (2010=2012	1	**Not Achieved** There was one maternal death from Influenza in 2013/14.

Outputs And Performance Measures 2013/14: Assessment Treatment and Rehabilitation

These are services provided to restore functional ability and enable people to live as independently as possible. Services are delivered in specialist inpatient units, outpatient clinics and also in home and work environments. Specialist geriatric and allied health expertise and advice is also provided to general practitioners, home and community care providers, residential care facilities and voluntary groups. An increase in the rate of people discharged home with support, rather than to residential care or hospital environments (where appropriate), is indicative of the responsiveness of services.

Establish a comprehensive Specialist Health Service for Older People (SHSOP) team, which consists of health professionals with geriatric and psycho-geriatric expertise, and which will use documented links and pathways with acute mental health, acute medical and surgical services and community providers who have an older persons' client base. The SHSOP service has inpatient as well as community teams.

MEASURES QUALITY (Q) – QUANTITY (V) – COVERAGE (C) – TIMELINESS (T)	NOTES	ACTUAL 2012/13	TARGET 2013/14	CURRENT NATIONAL AVERAGE	2013/14 ACHIEVED	COMMENTS ON 2013/14 PERFORMANCE
Total number of people (65+) accessing inpatient AT&R services	V	9,489 bed days, 654 inpatient discharges	≥8,982	n/a	8,897 bed days, 596 discharges	**Partially Achieved**
Attendances/Visits	V	5,871	≥10,455	n/a	4,497	**Not Achieved** The target of 10,455 was over- estimated and should have been revised lower. This measure has been deleted in the 2014/15 annual plan.
Number of community events that have community rehabilitation directed/delivered by AT&R	V	3,186	≥2,064	n/a	2,549	**Achieved**
Proportion of admissions into AT&R made by direct community referral	Q	50 cases,13%	≥26%	n/a	47 cases,12%	**Not Achieved**
AT&R patients (65+) are discharged into their own homes (not into ARRC)	Q	369, 56%	≥64%	n/a	64.7%, 380 discharges, (122 Marlborough 258 Nelson)	**Achieved**
Maintaining Bed Days Inpatient Geriatric ATR	V	7,261	≥7,906	n/a	8,645	**Achieved**

MEASURES QUALITY (Q) – QUANTITY (V) – COVERAGE (C) – TIMELINESS (T)	NOTES	ACTUAL 2012/13	TARGET 2013/14	CURRENT NATIONAL AVERAGE	2013/14 ACHIEVED	COMMENTS ON 2013/14 PERFORMANCE
Maintaining Bed Days Inpatient MH-ATR	V	3,136	≥2,555	n/a	3,412	**Achieved** This is an acute service, provided as needed, to people referred via the Older Persons Mental Health community team. The target is based on the provision of 8.5 beds at about 82% occupancy. The actual need has been higher.
Number of community events that have community rehabilitation directed or delivered by MH ATR	C	3,101	≥2,957	n/a	2,780	**Partially Achieved** This is a demand-driven service provided as needed.

Output Class Statement Of Financial Performance

$000s	2013-2014 ACTUAL	2013-2014 PLAN	VARIANCE
Revenue	**222,736**	**217,773**	**4,963**
Expenditure			
Personnel Costs	111,386	109,515	(1,871)
Outsourced services	11,576	7,757	(3,819)
Clinical Supplies	30,255	29,915	(340)
Infrastructure	30,738	30,528	(210)
Provider Payments	37,997	40,292	2,295
Total Expenditure	**221,952**	**218,006**	**(3,946)**
Net Surplus/(Loss)	**783**	**(233)**	**1,017**

REHABILITATION AND SUPPORT SERVICES

Output Class Description

Rehabilitation and support services provide people with the support and assistance they need to maintain maximum functional independence, either temporarily while recovering from illness/disability, or over the rest of their lives. These services are delivered following a 'needs assessment' process coordinated by Needs Assessment and Service Coordination (NASC) services and include domestic support, personal care, community nursing and community services provided in people's own homes and places of residence and also long and short-term residential care, respite and day services. Services are provided mostly for older people, mental health clients and for personal health clients with complex health conditions.Support services also include palliative care services for people who have end-stage conditions. It is important that they and their families are appropriately supported, enabling the person to live comfortably, have their needs met in a holistic and respectful way and die without undue pain and suffering. Delivery of these services may require coordination with other organisations and agencies, and may include public, private and part-funding arrangements.

Why Is This Output Class Significant For NMDHB?

Services that support people to manage their needs and live well, safely and independently in their own homes are considered to provide a much higher quality of life, as a result of staying active and positively connected to their communities. People whose needs are adequately met will also be less dependent on hospital and residential services and less likely to experience acute illness, crisis or deterioration of their conditions. Even when returning to, or maintaining full health is not possible, timely access to responsive support services enables people to maximise function with the greatest independence. In preventing deterioration and acute illness or crisis, these services have a major impact on the sustainability of hospital and specialist services and on the wider health system in general. Effective and responsive delivery of support services will help to reduce demand for acute services and improve access to other services and interventions. It will also free up resources for investment into early intervention, health promotion and prevention services that will help people stay healthier for longer. NMDHB has taken a restorative approach and has introduced individual packages of care to better meet people's needs, including complex packages of care for people assessed as eligible for residential care who would rather remain in their own homes. With an ageing population, it is vital that we ascertain the effectiveness of services in this area and that NMDHB uses the InterRAI (International Residential Assessment Instrument) tool to ensure people receive support services that best meet their needs and, where possible, support them to regain maximum functional independence.

Description of the sub-sets of services that make up this output class:

» **PALLIATIVE CARE SERVICES** are services that improve the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early intervention, assessment, treatment of pain and other supports. The DHB will target an increase in the number of sites that support the 'Liverpool Care of the Dying' pathway as this reflects best-practice care.

- Support Services

  › Needs Assessment and Services Coordination Services are services that determine a person's eligibility and need for publicly funded support services and then assist the person to determine the best mix of supports based on their strengths, resources and goals. The supports are delivered by an integrated team in the person's own home or community. The number of assessments completed is indicative of access and responsiveness.

  › Age Residential Care are services provided to meet the needs of a person who has been assessed as requiring long-term residential care in a hospital or rest home indefinitely. With an ageing population, a decrease in the number of subsidised bed days alongside an increase in the number of home-based support service hours is seen as indicative of more people being successfully supported to continue living at home.

› Respite, Carer Support and Day Programmes are services providing people with a break from a routine or regimented programme so that crisis can be averted or so that a specific health needs can be addressed. Services are provided by specialised organisations and are usually short-term or temporary in nature and may also include support and respite for families, caregivers and others affected. Services are expected to increase over time, as more people are supported to remain in their own homes.

› Home-Based Support Services are services designed to support people to continue living in their own homes and to restore functional independence. They may be short or longer-term in nature. Examples include domestic support, personal care and community nursing services. An increase in the number of people being supported is indicative of increased capacity in the system, and success is measured against a decreased or delayed entry into residential or hospital services.

› Community Support Services – Mental Health are services that support tangata whaiora/service users' recovery journey. This includes a wide range of services such as Home Based Support, Residential Housing, Planned and Crisis Respite, Day Activity and Living Skills, Peer Support, Vocational Support and Community Support Work to tangata whaiora/service users living in the community.

› Community Support Services – Intellectual Disability Support Services and Physical Disability Support Services are services that provide residential support in community home settings for people with intellectual and physical disability needs. This support is provided on a 24-hour-basis to support the person to maintain as ordinary life as possible to achieve their goals.

Outputs And Performance Measures 2013/14: Palliative Care Services

Services that:

» improve the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early intervention, assessment, treatment of pain and other support services

» ensure people have timely access to quality, culturally appropriate palliative care services

» co-ordinate care across hospital, community and support services

» implement the 'Liverpool Care Pathway' for palliative care services

» deliver a responsive system that supports a person's choice to die at home.

MEASURES QUALITY (Q) – QUANTITY (V) – COVERAGE (C) – TIMELINESS (T)	NOTES	ACTUAL 2012/13	TARGET 2013/14	CURRENT NATIONAL AVERAGE	2013/14 ACHIEVED	COMMENTS ON 2013/14 PERFORMANCE
Number of hospice/ palliative care patients receiving service delivered according to the service specification (national services framework)	V,T	458	461		423	**Achievement is demand driven** The number of patients receiving hospice care is demand driven.
Average quarterly total of palliative care patient consultations	V	502	490		774	**Achievement is demand driven** This is our Hospice Medical Officer nursing consultations for Nelson and Marlborough.
Percentage of provider settings delivering a Liverpool care pathway model of care	Q	81%	>75%		89.5%	**Achieved** 14 out of 18 age related residential care facilities are using a Liverpool Care pathway model of care.

Outputs And Performance Measures 2013/14: Needs Assessment & Support Services – Nasc, Age Residential Care, Respite, Carer Support, Day Programmes & Home Based Support, Intellectual Disability Support Services

InterRAI ensures that older people, who have an assessed need, receive support services in their homes whenever possible. NMDHB uses:

- regionally agreed service specifications for HBSS
- regionally agreed eligibility criteria and standardised approach to access
- locally agreed and expanded options for respite and day programmes for older people and their family/carers.

MEASURES QUALITY (Q) – QUANTITY (V) – COVERAGE (C) – TIMELINESS (T)	NOTES	ACTUAL 2012/13	TARGET 2013/14	CURRENT NATIONAL AVERAGE	2013/14 ACHIEVED	COMMENTS ON 2013/14 PERFORMANCE
The percentage of older people living in ARRC	C	7.0%	6.9%	N/A	6.8% (1,214 people)	**Achievement is demand driven** This is a demand-driven service provided as needed.
Total number of InterRAI first assessment	Q, V	752	814	N/A	796	**Partially Achieved**
Total number of InterRAI reassessments[23]	Q, V	2,123	2,222	N/A	2243	**Achieved**
Total number of service co-ordination events	V	8,682	≥9,100	N/A	8978	**Partially Achieved**
Total number of Respite care bed days[24] - allocated/used	V	4,825/2,581	5,428/3,400	N/A	5,075 /3,100	**Achievement is demand driven** The allocated figure is a snapshot as at 30 June 2014.
Total number of Respite care bed days – Carer Support Days – allocated/used	V	6,399/4,811	5,500/5,000	N/A	6,857/3,690	**Achievement is demand driven**
Total number home share day programme respite	V	Nil service	50 days	N/A	206	**Achievement is demand driven** Service commenced 01 April 2014. The allocated figure is a snapshot as at 30 June 2014 of the allocated annual eligibility for this service
Total number of Day Programme days	V	17,967 allocated, 13,469 used	≥16,100	N/A	18,073/ 14,778	**Achieved** The allocated figure is a snapshot as at 30/06/2014.
Total number of funded ARRC bed nights[25]	V	362,683	385,762	N/A	357,700	Partially Achieved

MEASURES QUALITY (Q) – QUANTITY (V) – COVERAGE (C) – TIMELINESS (T)	NOTES	ACTUAL 2012/13	TARGET 2013/14	CURRENT NATIONAL AVERAGE	2013/14 ACHIEVED	COMMENTS ON 2013/14 PERFORMANCE
Client satisfaction on survey: high level of satisfaction with NASC service (measured by a client satisfaction rating above 95%)	Q	97%	≥97%	N/A	-	Unable to report on this measure in 2013/14. The NASC Client Satisfaction survey will be conducted again in 2014/15 & 2015/16.
NASC response time to assessment	T	87.8% within 20 days	≥90% within 20 days	N/A	90.37% within 20 days	Achieved
The number of rest home new admissions[2]6	V	353	364	N/A	475	Achievement is demand driven
Total number of clients receiving home based support[2]7	Q,V	2,614	2,992	N/A	2,552	Achievement is demand driven

Outputs And Performance Measures 2013/14: Community Support Services – Mental Health

These services are targeted to improve service user recovery. Accessing specialist mental health and addiction services early prevents deterioration in mental health.

MEASURES QUALITY (Q) – QUANTITY (V) – COVERAGE (C) – TIMELINESS (T)	NOTES	ACTUAL 2012/13	TARGET 2013/14	CURRENT NATIONAL AVERAGE	2013/14 ACHIEVED	COMMENTS ON 2013/14 PERFORMANCE
Develop & implement use of shared recovery/ relapse plan across specialist and NGO services	Q	Nil	Proposed plan by December 2013	N/A	Funding for this project was through an external agency and has unfortunately been withdrawn. NMDHB Mental Health Directorate will re-consider this action and look at alternative ways to review documentation among providers and where sharing can occur.	Not Achieved

MEASURES QUALITY (Q) – QUANTITY (V) – COVERAGE (C) – TIMELINESS (T)	NOTES	ACTUAL 2012/13	TARGET 2013/14	CURRENT NATIONAL AVERAGE	2013/14 ACHIEVED	COMMENTS ON 2013/14 PERFORMANCE
Increase in improvement in National Consumer Satisfaction Survey (Q20 – Overall Service Satisfaction)	Q	79.97%	≥85%	81.3%	78.3%.	**Partially Achieved** There appears to have been has been a slight reduction in the satisfaction rating for NMDHB mental health services. The results will partly depend on the response rate to the survey, who responds and sample validity. The National Mental Health Consumer Satisfaction Survey is one way of receiving feedback about our services from consumers. Narrative feedback in these surveys is reviewed and where there are identifiable concerns, these are addressed with the appropriate areas and feedback given to consumers.
Training sessions (group) provided to primary care and/or ARRC providers	Q, V	n/a (new services)	4 (1 per quarter)	N/A	41	**Achieved** 28 training sessions in Nelson, 13 in Marlborough.
Liaison contacts -1:1 advice/training with primary care and/or ARRC providers	Q,V	n/a (new services)	≥200 per quarter	N/A	904	**Achieved** 619 liaison contacts in Nelson, 285 in Marlborough.
Training sessions (group) provided to primary care and/or ARRC providers	Q,V	n/a (new services	≥60 group sessions (15 per quarter) Specialist Nursing Education Age Related Residential Care	N/A	61	**Achieved** There were forum updates to HOP continuum group and 57 ARRC education sessions or similar.

Output Class Statement Of Financial Performance

$000s	2013-2014 ACTUAL	2013-2014 PLAN	VARIANCE
Revenue	**92,123**	**91,477**	**646**
Expenditure			
Personnel Costs	20,856	21,035	179
Outsourced services	972	964	(8)
Clinical Supplies	3,313	3,151	(162)
Infrastructure	6,154	6,866	712
Provider Payments	58,780	60,090	1,310
Total Expenditure	**90,075**	**92,106**	**2,031**
Net Surplus/(Loss)	**2,048**	**(629)**	**2,676**

Financial Statements

CONSOLIDATED STATEMENT OF FINANCIAL PERFORMANCE

For The Year Ended 30 June 2014

	Note	PARENT & GROUP 2014 Budget $000	2014 Actual $000	2013 Actual $000
Income				
Revenue	4	423,167	427,360	414,933
Other Operating income	5	3,506	4,634	3,736
Finance income	6	1,200	2,180	1,767
Total Income		**427,873**	**434,174**	**420,436**
Expenses				
Personnel Costs	7	155,369	156,105	153,206
Outsourced Services		10,665	14,374	11,788
Clinical Supplies		30,856	31,630	31,741
Infrastructure & Non-Clinical Expenses		23,745	23,341	22,989
Payments to non-Health Board Providers		182,859	180,564	179,313
Other Operating Expenses	8	2,229	2,470	2,568
Depreciation and amortisation expense	15,16	11,742	11,193	11,404
Finance Costs	6	2,932	3,131	2,926
Capital Charge	9	7,475	6,974	7,430
Total Expenses		**427,872**	**429,782**	**423,366**
Net Surplus/(Deficit)		**1**	**4,392**	**(2,930)**

Explanations of significant variances against budget are detailed in note 29.

The accompanying notes form part of and are to be read in conjunction with these financial statements.

CONSOLIDATED STATEMENT OF COMPREHENSIVE INCOME

For The Year Ended 30 June 2014

	Note	PARENT & GROUP 2014 Budget $000	2014 Actual $000	2013 Actual $000
Net Surplus/(Deficit)		1	4,392	(2,930)
Other Comprehensive Income				
Revaluation of Property, Plant and Equipment	21	-	(449)	(3,565)
Total Comprehensive Income		**1**	**3,943**	**(6,495)**

The revaluation of property, plant, and equipment represents the revaluation on Land and Buildings as at 30 June 2012. Explanations of significant variances against budget are detailed in note 29.

The accompanying notes form part of and are to be read in conjunction with these financial statements.

CONSOLIDATED STATEMENT OF MOVEMENTS IN EQUITY

For The Year Ended 30 June 2014

	Note	PARENT & GROUP 2014 Budget $000	2014 Actual $000	2013 Actual $000
Equity at Beginning of the Year		90,341	86,846	93,888
Comprehensive Income				
Net Surplus/(Deficit)		1	4,392	-2,930
Other Comprehensive Income		-	(449)	-3,565
Total Comprehensive Income		**1**	**3,943**	**(6,495)**
Owner Transactions				
Equity Injections		-	-	-
Equity Repayments		(547)	(547)	(547)
Total Equity at the End of the Year	**22**	**89,795**	**90,242**	**86,846**

Explanations of significant variances against budget are detailed in note 29. The accompanying notes form part of and are to be read in conjunction with these financial statements.

CONSOLIDATED STATEMENT OF FINANCIAL POSITION

As At 30 June 2014

	Note	PARENT & GROUP 2014 Budget $000	2014 Actual $000	2013 Actual $000
Assets				
Current Assets				
Cash and Cash Equivalents	10	12,947	45,450	30,445
Debtors and Other Receivables	11	12,800	11,056	10,970
Inventories	12	2,400	2,171	2,048
Prepayments		450	328	411
Non-current Assets Held for Sale	13a	1,500	-	4,131
Total Current Assets		**30,097**	**59,005**	**48,005**
Non Current Assets				
Prepayments		-	182	130
Other Financial Assets	14	3,019	2,341	3
Non-current Assets being Prepared for Sale	13b	-	751	-
Property, Plant and Equipment	15	174,564	158,378	157,272
Intangible Assets	16	8,110	4,693	3,602
Total Non Current Assets		**185,693**	**166,344**	**161,007**
Total Assets		**215,790**	**225,349**	**209,012**
Liabilities				
Current Liabilities				
Creditors & Other Payables	17	25,700	27,841	23,175
Loans & Borrowings	18	8,223	8,765	11,141
Employee Entitlements	19	30,635	30,895	29,707
Provisions	20	1,300	1,054	1,430
Total Current Liabilities		**65,858**	**68,556**	**65,453**
Non Current Liabilities				
Loans & Borrowings	18	47,537	55,645	45,252
Employee Entitlements	19	12,600	10,907	11,461
Total Non Current Liabilities		**60,137**	**66,552**	**56,713**
Total Liabilities		**125,995**	**135,108**	**122,166**
Net Assets		**89,795**	**90,242**	**86,846**
Equity				
Crown Equity	21	29,157	28,587	29,134
Other Reserves	21	50,988	46,974	47,423
Retained Earnings/(Losses)	21	9,649	14,681	10,289
Total Equity		**89,795**	**90,242**	**86,846**

Explanations of significant variances against budget are detailed in note 29. The accompanying notes form part of and are to be read in conjunction with these financial statements.

CONSOLIDATED STATEMENT OF CASH FLOWS

For The Year Ended 30 June 2014

	Note	PARENT & GROUP 2014 Budget $000	2014 Actual $000	2013 Actual $000
Cash Flows from Operating Activities				
Cash was provided from:				
Receipts from Ministry of Health and patients		426,668	431,621	421,138
Interest received		**1,200**	**2,180**	**1,767**
		427,868	433,801	422,905
Cash was disbursed to:				
Payments to employees		155,369	155,704	152,944
Payments to suppliers		250,354	247,476	250,672
Capital Charge		7,475	6,974	7,430
Interest paid		2,932	3,131	2,926
Net GST paid/(refunded)		-	184	-2,649
		416,130	413,469	411,323
Net cash inflow/(outflow) from operating activities	**22**	**11,738**	**20,332**	**11,582**
Cashflows from Investing Activities				
Cash was provided from:				
Sale of property, plant & equipment		2,052	2,065	40
Cash inflow on maturity of investments		-	-	25,285
		2,052	2,065	25,325
Cash was applied to:				
Acquisition of property, plant & equipment		18,590	4,502	6,219
Acquisition of intangible assets		8,779	1,352	2,431
Acquisition of investments		546	-	-
		27,915	5,854	8,650
Net cash inflow/(outflow) from investment activities		**(25,863)**	**(3,789)**	**16,675**
Cashflows from Financing Activities				
Cash was provided from:				
Loans Raised		-	-	-
Finance Leases Raised			-	-
Equity Injections		-	-	-
Cash was applied to:				
Equity Repaid		547	547	547
Repayment of Borrowings		-	-	1,020
Payment of Finance Lease Liabilities		672	991	1,045
Net cash inflow /(outflow) from financing activities		**(1,219)**	**(1,538)**	**(2,612)**
Net increase/(decrease) in cash and cash equivalents		(15,344)	15,005	25,645
Add Cash and cash equivalents at 1 July		28,291	30,445	4,800
Adjustment to Opening Balance due to reclassification of				
Cash and cash equivalents as at 30 June		**12,947**	**45,450**	**30,445**

The GST component of operating activities reflects the net GST paid and received with the Inland Revenue Department. The GST component has been presented on a net basis, as the gross amounts do not provide meaningful information for financial statement purposes and to be consistent with the presentation basis of the other primary financial statements.

Equipment totalling $620,637 (2013: $577,633) was acquired by means of finance leases during the year.

In September 2013 Nelson Marlborough DHB set up a finance lease to account for the lease of the completed Golden Bay Integrated Health Centre facilities to the Golden Bay Community Health Trust.

2014 $8.4m (2013 Nil). Refer to Note 18(b).

Explanations of significant variances against budget are detailed in note 29.

CONSOLIDATED STATEMENT OF COMMITMENTS

For The Year Ended 30 June 2014

	PARENT & GROUP	
	2014 Actual $000	**2013 Actual $000**
Capital Commitments		
Property, Plant & Equipment	1,783	555
Intangible Assets	79	37
Total capital commitments	**1,862**	**592**
Non-cancellable commitments - Provider Commitments		
Not later than one year	13,136	13,029
Later than one year and not later than two years	6,092	2,341
Later than two years and not later than five years	6,052	4,082
Later than five years	10,347	10,193
	35,627	**29,645**
Non-cancellable commitments - Operating Lease Commitments		
Not later than one year	653	653
Later than one year and not later than two years	539	498
Later than two years and not later than five years	1,263	1,228
Later than five years	1,393	1,693
	3,848	**4,072**
Non-cancellable commitments - Finance Lease Commitments		
Not later than one year	1,043	672
Later than one year and not later than two years	688	260
Later than two years and not later than five years	1,482	-
Later than five years	14,350	-
	17,563	**932**

Non-cancellable commitments - Other

Nelson Marlborough DHB has entered into non-cancellable contracts for the provision of services.		
Not later than one year	3,681	1,214
Later than one year and not later than two years	23	299
Later than two years and not later than five years	-	23
Later than five years	-	-
	3,704	**1,536**

Total Commitments	**62,604**	**36,777**

Capital commitments represent capital expenditure contracted for at balance date but not yet incurred. The Provider Commitments disclosed in this note include committed obligations for health purchasing expenditure with NGOs. The Board is also obligated to funding significant streams of 'demand driven' health purchasing expenditure. Commitments of this nature are in place for the purchase of pharmacy, GP services and for Health of Older People residential and community based services. Because this expenditure is 'demand driven' it is not possible to quantify the obligation in this note. xpenditure of this nature in the 2014 year totalled $116.0 million (2013: $115.0 million).

CONSOLIDATED STATEMENT OF CONTINGENCIES

For The Year Ended 30 June 2014

CONTINGENT LIABILITIES

A contingent liability not recognised in these financial statements is for the removal of asbestos from some of the Board's buildings. The amount of this liability cannot be reliably calculated.

Nelson Marlborough DHB also has no contingent liabilities as at 30 June 2014 (2013: up to $0.3m).

CONTINGENT ASSETS

Nelson Marlborough DHB is seeking legal redress against a third party for overexpenditure and has recorded a contingent asset of $1.78m (2013: $1.78).

NOTES TO THE FINANCIAL STATEMENTS

For The Year Ended 30 June 2014

1) REPORTING ENTITY

Nelson Marlborough District Health Board ("Nelson Marlborough DHB") is a Health Board established by the New Zealand Public Health and Disability Act 2000. Nelson Marlborough DHB is a Crown Entity in terms of the Crown Entities Act 2004, owned by the Crown and domiciled in New Zealand. Nelson Marlborough DHB is a reporting entity for the purposes of the New Zealand Public Health and Disability Act 2000, the Financial Reporting Act 1993, the Public Finance Act 1989 and the Crown Entities Act 2004.

The Group consists of Nelson Marlborough DHB and its subsidiary, Nelson Marlborough Hospitals Charitable Trust.

Nelson Marlborough DHB's activities involve the delivery of health and disability services and mental health services in a variety of ways to the community. Therefore, Nelson Marlborough DHB has designated itself and its subsidiaries as public benefit entities, for the purposes of the New Zealand equivalents to International Financial Reporting Standards (NZ IFRS).

The financial statements of Nelson Marlborough DHB and group are for the year ended 30 June 2014. The financial statements were approved by the Board on dd/mm/2014 [to be inserted].

2) BASIS OF PREPARATION

a) Statement of Compliance

The consolidated financial statements have been prepared in accordance with the requirements of the NZ Public Health & Disability Act 2000 and the Crown Entities Act 2004, which includes the requirement to comply with Generally Accepted Accounting Practice in New Zealand (NZ GAAP). They comply with New Zealand equivalents to International Financial Reporting Standards (NZ IFRS), and other applicable Financial Reporting Standards, as appropriate for public benefit entities.

b) Measurement Base

The financial statements are prepared on the historical cost basis modified by the revaluation of certain assets and liabilities as identified in the statement of accounting policies.

c) Functional and presentation currency

The financial statements are presented in New Zealand Dollars (NZD) , rounded to the nearest thousand. The functional currency of Nelson Marlborough DHB and its subsidiary is New Zealand dollars.

d) Management Judgements, Estimates & Assumptions

The preparation of financial statements in conformity with NZ IFRS requires management to make judgements, estimates and assumptions that affect the application of policies and reported amounts of assets and liabilities, income and expenses. The estimates and associated assumptions are based on historical experience and various other factors that are believed to be reasonable under the circumstances, the results of which form the basis of making judgements about carrying values of assets and liabilities that are not readily apparent from other sources. Actual results may differ from these estimates.

The estimates and underlying assumptions are reviewed on an ongoing basis. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period, or in the period of the revision and future periods if the revision affects both current and future periods.

Judgements made by management in the application of NZ IFRS that have a significant effect on the financial statements and estimates with a significant risk of material adjustment in the next year are discussed in note 28.

e) Standards, amendments and interpretations issued that are not yet effective and have not been early adopted

Certain new standards, amendments and interpretations to existing standards have been published that are not effective for the year ended 30 June 2014 and have not been applied in preparing these financial statements. The following standards, amendments and interpretations which are relevant to Nelson Marlborough DHB are:

NZ IFRS 9

NZ IFRS 9 Financial Instruments will eventually replace NZ IAS 39 Financial Instruments: Recognition and Measurement. NZIAS 39 is being replaced in three main phases. The first phase on the classification and measurement of financial assets has been completed and has been published in the new financial instrument standard NZ IFRS 9. NZ IFRS 9 uses a single approach to determine whether a financial asset is measured at amortised cost or fair value, replacing the many different rules in NZ IAS 39. The approach in NZ IFRS 9 is based on how an entity manages its financial instruments and the contractual cash flow characteristics of the financial assets. The financial liability requirements are the same as those of NZ IAS 39, except for when an entity elects to designate a financial liability at fair value through the surplus/deficit. The new standard is required to be adopted for the year ended 30 June 2016. Nelson Marlborough DHB has not yet assessed the effect of the new standard and does not expect to early adopt it.

The Minister of Commerce has approved a new Accounting Standards Framework (incorporating a Tier

Strategy) developed by the External Reporting Board (XRB). Under this Accounting Standards Framework, the DHB is classified as a Tier 1 reporting entity and it will be required to apply full public sector Public Benefit Entity Accounting Standards (PAS). These standards are being developed by the XRB and are mainly based on current International Public Sector Accounting Standards. The effective date for the new standards for public sector entities is expected to be for reporting periods beginning on or after 1 July 2014. This means the DHB expects to transition to the new standards in preparing its 30 June 2015 financial statements. As the PAS are still under development, the DHB is unable to assess the implications of the new Accounting Standards Framework at this time.

Due to the change in the Accounting Standards Framework for public benefit entities, it is expected that all new NZ IFRS and amendments to existing NZ IFRS will not be applicable to public benefit entities. Therefore, the XRB has effectively frozen the financial reporting requirements for public benefit entities up until the new Accounting Standards Framework is effective. Accordingly, no disclosure has been made about new or amended NZ IFRS that exclude public benefit entities from their scope.

f) Changes in Accounting Policies

There have been no changes in accounting policies during the financial yea

3) ACCOUNTING POLICIES

BASIS OF CONSOLIDATION

SUBSIDIARIES

Subsidiaries are those entities controlled by Nelson Marlborough DHB. Control exists when Nelson Marlborough DHB has the power, directly or indirectly, to govern the financial and operating policies of an entity so as to obtain benefits from its activities.

Nelson Marlborough Hospitals Charitable Trust is a subsidiary of Nelson Marlborough DHB. The financial results of the Trust are not material and have not been consolidated. Therefore, the financial results disclosed for both the parent and group are the same. Information relating to the Trust is note 26.

BUDGET FIGURES

The budget figures were approved by the Board at the beginning of the year in its District Annual Plan and included in the Statement of Intent tabled in parliament. The budget figures have been prepared in accordance with NZ GAAP. They comply with NZ IFRS and other applicable Financial Reporting Standards as appropriate for public benefit entities. Those standards are consistent with the accounting policies adopted by Nelson Marlborough DHB for the preparation of the financial statements.

BORROWING COSTS

Nelson Marlborough DHB has elected to defer the adoption of NZ IAS 23 Borrowing Costs (Revised 2007) in accordance with its transitional provisions that are applicable to public benefit entities. Consequently, all Borrowing costs are recognised as an expense in the period in which they are incurred.

CAPITAL CHARGE

The capital charge is recognised as an expense in the period to which the charge relates.

CASH AND CASH EQUIVALENTS

Cash and cash equivalents means cash on hand, call deposits held with banks, short term deposits that have maturities of three months or less, and bank overdrafts.

CREDITORS AND OTHER PAYABLES

Creditors and other payables are initially measured at fair value and subsequently measured at amortised cost using the effective interest method. Payables of short duration are not discounted.

DEBTORS AND OTHER RECEIVABLES

Debtors and other receivables are initially measured at fair value and subsequently measured at amortised cost using the effective interest method, less any provision for impairment. Receivables of short duration are not discounted.

Impairment of a receivable is established when there is objective evidence that Nelson Marlborough DHB will not be able to collect amounts due according to the original terms of the receivable. Significant financial difficulties of the debtor, probability that the debtor will enter into bankruptcy, and default in payments are considered indicators that the debtor is impaired. The amount of the impairment is the difference between the asset's carrying amount and the estimated recoverable amount. The carrying amount of the asset is reduced through the use of an allowance account, and the amount of the loss is recognised in the surplus or deficit. When the receivable is uncollectable, it is written off and the allowance reversed.

EMPLOYEE ENTITLEMENTS

a) Defined Contribution Plans

Obligations for contributions to defined contribution pension plans, such as Kiwisaver and the State Sector Retirement Savings Scheme, are recognised as an expense when they are incurred.

b) Defined Benefit Plans

Nelson Marlborough DHB does not make contributions to defined benefit pension plans.

c) Long Service Leave, Sabbatical Leave, Sick Leave, and Retirement Gratuities

Nelson Marlborough DHB's net obligation in respect of long service leave, sabbatical leave, sick leave and retirement leave is the amount of future benefit that employees have earned in return for their service in the current and prior periods. The obligation is valued on an actuarial basis.

Those entitlements expected to be settled within 12 months of balance date are classified as a current liability. Where settlement is expected more than 12 months after balance date, the entitlements are classified as non-current liabilities.

d) Annual Leave, Conference Leave and Medical Education leave

Annual leave, conference and medical education leave are short-term obligations and are calculated on an actual entitlement basis at current rates of pay.

Nelson Marlborough DHB accrues the obligation for paid absences when the obligation both relates to employees' past services and it accumulates.

EQUITY

Equity is measured as the difference between total assets and total liabilities. Equity is disaggregated and classified into the following components:

- - Crown equity
- - Retained earnings
- - Revaluation reserves

Revaluation reserves are related to the revaluation of land and buildings to fair value.

FINANCIAL INSTRUMENTS

NON-DERIVATIVE FINANCIAL INSTRUMENTS

Non-derivative financial instruments comprise investments in equity securities, debtors and other receivables, cash and cash equivalents, loans and borrowings, and creditors and other payables.

a) Recognition

A financial instrument is recognised if Nelson Marlborough DHB becomes a party to the contractual provisions of the instrument.

Non-derivative financial instruments are initially recognised at fair value plus transaction costs unless they are carried at fair value through other comprehensive income in which case the transaction costs are recognised in the surplus or deficit. Subsequent to initial recognition, non-derivative financial instruments are measured as described below.

Purchases and sales of financial assets are recognised on trade-date, the date on which Nelson Marlborough DHB commits to purchase or sell the asset. Financial assets are derecognised when Nelson Marlborough DHB's rights to receive cash flows from the financial assets have expired or if the DHB transfers the financial asset to another party without retaining control or substantially all risks and rewards of ownership. Financial liabilities are derecognised if Nelson Marlborough DHB's obligations specified in the contract expire or are discharged.

Cash and cash equivalents comprise cash balances, call deposits, and other deposits with original maturities of no more than three months. Bank overdrafts that are repayable on demand and form an integral part of Nelson Marlborough DHB's cash management are included as a component of cash and cash equivalents for the purpose of the Statement of Cash Flows.

Nelson Marlborough DHB classifies its financial instruments into the following categories: Fair Value through other comprehensive income, loans and receivables, fair value through surplus or deficit, and amortised cost.

b) Measurement

FAIR VALUE THROUGH OTHER COMPREHENSIVE INCOME

Nelson Marlborough DHB's investments in equity securities are classified as fair value through other comprehensive income. Subsequent to initial recognition, they are measured at fair value and changes therein, other than impairment losses, and foreign exchange gains and losses are recognised in other comprehensive income. When an investment is derecognised, the cumulative gain or loss in equity is transferred to surplus or deficit.

The fair value of financial instruments traded in active markets is based on quoted market prices at balance date. The quoted market price used is the current bid price.

Nelson Marlborough DHB classifies its investment in equity securities as fair value through other comprehensive income. However, the shares have been recorded at cost as they do not have a quoted price in an active market and their fair value cannot be reliably measured.

LOANS AND RECEIVABLES

Loans and receivables are non-derivative financial assets with fixed or determinable payments that are not quoted in an active market. They are included in current assets, except for maturities greater than 12 months after balance date, which are included in non-current assets.

After initial recognition they are measured at amortised cost using the effective interest method less impairment. Receivables of short duration are not discounted. Gains and losses when the asset is impaired or derecognised are recognised in the surplus or deficit.

Nelson Marlborough DHB classifies debtors and other receivables, and cash and cash equivalents as Loans and Receivables.

OTHER FINANCIAL INSTRUMENTS

Financial instruments that are not classified as fair value through other comprehensive income, or fair value through surplus or deficit are measured at amortised cost using the effective interest method, less any impairment losses.

Nelson Marlborough DHB classifies creditors and other payables, finance leases, and secured loans as Other Financial Instruments.

DERIVATIVE FINANCIAL INSTRUMENTS

Nelson Marlborough DHB does not have any derivative financial instruments.

FOREIGN CURRENCY

Transactions in foreign currencies are translated to New Zealand dollars at the foreign exchange rate at the date of the transaction. Monetary assets and liabilities denominated in foreign currencies at the balance sheet date are translated to New Zealand

Foreign exchange differences arising on translation are recognised in the Statement of Consolidated Income. Non-monetary assets and liabilities that are measured in terms of historical costs in a foreign currency are translated using the exchange rate.

GOODS AND SERVICES TAX

All items in the financial statements are exclusive of goods and services tax (GST) with the exception of receivables and payables which are stated inclusive of GST. Where GST is irrecoverable as an input tax, then it is recognised as part of the related asset or expense.

The net amount of GST recoverable from, or payable to, the Inland Revenue Department (IRD) is included as part of receivables or payables in the Statement of Financial Position.

The net GST paid to, or received from the IRD, including the GST relating to investing and financing activities, is classified as an operating cash flow in the Statement of Cash Flows.

Commitments and contingencies are disclosed exclusive of GST.

IMPAIRMENT

a) Recognition

Nelson Marlborough DHB considers at each balance date whether there is any indication that its assets other than investment property, inventories and inventories held for distribution may be impaired. If any such indication exists, the asset's recoverable amount is estimated. Given that the future economic benefits of the DHB's assets are not directly related to the ability to generate net cash flows, the value in use of these assets is measured on the basis of depreciated replacement cost.

If an asset's carrying amount exceeds its recoverable amount, the asset is impaired and the carrying amount is written down to the recoverable amount. For revalued assets the impairment loss is recognised against the revaluation reserve for that class of asset. Where that results in a debit balance in the revaluation reserve, the balance is recognised in the surplus or deficit. For assets not carried at a revalued amount, the total impairment loss is recognised in the surplus or deficit.

For intangible assets that have an indefinite useful life and intangible assets that are not yet available for use, the recoverable amount is estimated at each balance date and was estimated at the date of transition.

When a decline in the fair value of an available-for-sale financial asset has been recognised directly in equity and there is objective evidence that the asset is impaired, the cumulative loss that had been recognised directly in equity is recognised in the surplus or deficit even though the financial asset has not been derecognised. The amount of the cumulative loss that is recognised in the surplus or deficit is the difference between the acquisition cost and the current fair value, less any impairment loss on that financial asset previously recognised in the surplus or deficit.

Impairment losses on an individual basis are determined by an evaluation of the exposures on an instrument by instrument basis. All individual trade receivables that are considered significant are subject to this approach. For trade receivables which are not significant on an individual basis, collective impairment is assessed on a portfolio basis based on number of days overdue, and taking into account the historical loss experience.

Impairment gains and losses, for items of property, plant and equipment that are revalued on a class of assets basis, are also recognised on a class basis.

b) Recoverable Amount

The estimated recoverable amount of receivables carried at amortised cost is calculated as the present value of estimated future cash flows, discounted at their original effective interest rate. Receivables with a short duration are not discounted.

The estimated recoverable amount of other assets is the greater of their fair value less costs to sell and value in use. Given that the future economic benefits of the DHB's assets are not directly related to the ability to generate net cash flows, the value in use of these assets is measured on the basis of depreciated replacement cost.

c) Reversals of Impairment

Impairment losses are reversed when there is a change in the estimates used to determine the recoverable amount.

An impairment loss is reversed only to the extent that the asset's carrying amount does not exceed the carrying amount that would have been determined, net of depreciation or amortisation, if no impairment loss had been recognised.

An impairment loss on an equity instrument investment classified as fair value through other comprehensive income or on items of property, plant and equipment carried at fair value is reversed through the relevant reserve. All other impairment losses are reversed through the surplus or deficit.

The reversal of an impairment loss on a revalued asset is credited to the revaluation reserve. However, to the extent that an impairment loss for that class of asset was previously recognised in the surplus or deficit, a reversal of the impairment loss is also recognised in the surplus or deficit. For assets not carried at a revalued amount the reversal of an impairment loss is recognised in the surplus or deficit.

INCOME TAX

Nelson Marlborough DHB is a Crown Entity under the New Zealand Public Health and Disability Act 2000 and is exempt from income tax under section CW38 of the Income Tax Act 2007. Accordingly, no charge of income tax has been provided for.

INTANGIBLE ASSETS

a) Software acquisition and development

Computer software licenses acquired by Nelson Marlborough DHB are capitalised on the basis of the costs incurred to acquire and bring to use the specific software.

Costs that are directly associated with the development of software for internal use by Nelson Marlborough DHB are recognised as an intangible asset. Direct costs include the software development, employee costs and an appropriate portion of relevant overheads.

Staff training costs are recognised as an expense when incurred.

Costs associated with maintaining computer software are recognised as an expense when incurred.

Costs associated with the development and maintenance of Nelson Marlborough DHB's website are recognised as an expense when incurred.

b) Amortisation

Amortisation is recognised in the surplus or deficit on a straight line basis over the estimated useful lives of intangible assets unless such lives are indefinite. Other intangible assets are amortised from the date they are available for use. The estimated useful lives are as follows:

TYPE OF ASSET: Software

ESTIMATED LIFE: 3 - 10 years

AMORTISATION RATE: 10 - 34 %

c) Health Benefits Ltd

The FPSC rights represent the DHB's right to access, under a service level agreement, shared finance, procurement and supply chain (FPSC) services provided using assets funded by the DHBs.

The intangible asset is recognised at the cost of the capital invested by the DHB in the FPSC Programme, a national initiative, facilitated by Health Benefits Limited (HBL), whereby all 20 DHBs will move to a shared services model for the provision of finance, procurement and supply chain services.

The rights are considered to have an indefinite life as the DHBs have the ability and intention to review the service level agreement indefinitely and the fund established by HBL through the on-charging of

depreciation on the FPSC assets to the DHBs will be used to, and is sufficient to, maintain the FPSC assets standard of performance or service potential indefinitely.

As the FPSC rights are considered to have an indefinite life, the intangible asset is not amortised and will be tested for impairment annually.

INVENTORIES HELD FOR DISTRIBUTION

Inventories classified as held for distribution are stated at cost (calculated using the weighted average cost method) adjusted, where applicable, for any loss of service potential. The loss of service potential of inventory held for distribution is determined on the basis of obsolescence. Where inventories are acquired at no cost or for nominal consideration, the cost is the current replacement cost at the date of acquisition.

Any write-down from cost to current replacement cost is recognised in the surplus or deficit in the period when the write-down occurs.

INVESTMENTS

a) Bank Deposits

Investments in bank deposits are initially measured at fair value plus transaction costs. After initial recognition, investments in bank deposits are measured at amortised cost using the effective interest method, less any provision for impairment.

At each balance date, Nelson Marlborough DHB assesses whether there is any objective evidence that an investment is impaired.

LEASES

a) Finance Leases

Leases which effectively transfer to Nelson Marlborough DHB substantially all the risks and benefits incident to ownership of the leased asset are classified as finance leases. At the commencement of the lease, Nelson Marlborough DHB recognises finance leases as assets and liabilities in the Statement of Financial Position at the lower of the fair value of the leased asset or the present value of the minimum lease payments.

The finance charge is charged to the surplus or deficit over the lease period so as to produce a constant periodic rate of interest on the remaining balance of the liability.

The amount recognised as an asset is depreciated over the shorter of its useful life and the lease term.

b) Operating Leases

Leases where the lessor effectively retains substantially all the risks and benefits of ownership of the leased items are classified as operating leases. Payments under these leases are recognised as expenses in the periods in which they are incurred.

LOANS AND BORROWINGS

Loans and borrowings are recognised initially at fair value less attributable transactions costs. Subsequent to initial recognition, loans and borrowings are stated at amortised cost with any difference between cost and redemption value being recognised in the surplus or deficit over the period of the borrowings on an effective interest basis.

Borrowings are classified as current liabilities unless Nelson Marlborough DHB has an unconditional right to defer settlement of the liability for at least 12 months after balance date.

NON-CURRENT ASSETS HELD FOR SALE

Non-current assets held for sale are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. Non-current assets held for sale are measured at the lower of their carrying amount and fair value less costs to sell.

For revalued assets, any impairment losses for write-downs of non-current assets held for sale are recognised in other comprehensive income to the extent the impairment loss does not exceed the amount in the revaluation reserve in equity for that same class of asset. For assets not carried at a revalued amount, the total impairment loss is recognised in the surplus or deficit.

Any increases in fair value (less costs to sell) are recognised up to the level of any impairment losses that have been previously recognised.

Non-current assets held for sale (including those that are part of a disposal group) are not depreciated or amortised while they are classified as held for sale.

PROPERTY, PLANT AND EQUIPMENT

a) Classes of property, plant and equipment.

- The major classes of property, plant and equipment are as follows:
- Freehold Land
- Freehold Buildings
- Plant and Equipment
- Motor Vehicles
- Work in Progress

b) Recognition and Measurement

Under section 95(3) of the New Zealand Public Health and Disability Act 2000, the assets of Nelson Marlborough Health Services Limited (a Hospital and Health Service Company) vested in Nelson Marlborough District Health Board on 1 January 2001. Accordingly, assets were transferred to Nelson Marlborough DHB and their net book values recorded in the books of the Hospital and Health Service Company. In effecting this transfer, the Health Board has recognised the cost and accumulated depreciation amounts from the records of the Hospital and Health Service Company. The vested assets have since been revalued and are depreciated over their remaining useful lives.

Except for land and buildings and the assets vested from the Hospital and Health Service Company (see above), items of property, plant and equipment are stated at cost, less accumulated depreciation and impairment losses.

Cost includes expenditures that are directly attributable to the acquisition of the asset. The cost of self-constructed assets includes the cost of materials and direct labour, any other costs directly attributable to bringing the asset to a working condition for its intended use, and the costs of dismantling and removing the items and restoring the site on which they are located. Purchased software that is integral to the functionality of the related equipment is capitalised as part of that equipment.

Where an asset is acquired at no cost, or for a nominal cost, it is recognised at fair value when control over the asset is obtained.

When parts of an item of property, plant and equipment have different useful lives, they are accounted for as separate items (major components) of property, plant and equipment.

c) Subsequent Costs

Subsequent costs are added to the carrying amount of an item of property, plant and equipment when that cost is incurred if it is probable that the service potential or future economic benefits embodied within the new item will flow to Nelson Marlborough DHB and the cost of the item can be reliably measured. All other costs are recognised in the surplus or deficit as an expense as incurred.

d) Revaluation of land and buildings

Land and buildings are revalued every three years to fair value as determined by an independent registered valuer by reference to the highest and best use. Assets for which no open market evidence exists are revalued on an Optimised Depreciated Replacement Cost basis.

Additions between revaluations are recorded at cost.

The results of revaluing land and buildings are credited or debited to an asset revaluation reserve for that class of asset and other comprehensive income. Where a revaluation results in a debit balance in the asset revaluation reserve, the debit balance will be expensed in the surplus or deficit. Any decreases in value relating to a class of land and buildings are debited directly to other comprehensive income and the revaluation reserve, to the extent that they reverse previous surpluses and are otherwise recognised as

an expense in the surplus or deficit.

The carrying values of revalued assets are reviewed annually to ensure that those values are not materially different to fair value. If there is evidence supporting a material difference, then the asset class will be revalued.

e) Depreciation

Depreciation is provided on a straight-line basis on all Property, Plant and Equipment other than freehold land, at rates which will write off the cost (or valuation) of the assets to their estimated residual values over their useful lives.

The estimated useful lives of major classes of assets and resulting rates are as follows:

TYPE OF ASSET: Buildings and Building Fitout

ESTIMATED LIFE: 10 to 76 years

DEPRECIATION RATE: 1.3 - 10%

TYPE OF ASSET: Plant and equipment

ESTIMATED LIFE: 2 to 20 years

DEPRECIATION RATE: 5 - 50%

TYPE OF ASSET: Motor vehicles

ESTIMATED LIFE: 5 to 16 years

DEPRECIATION RATE: 6.25 - 20%

TYPE OF ASSET: Leased Assets

ESTIMATED LIFE: 2 to 7.25 years

DEPRECIATION RATE: 13.79% - 50%

The residual values and useful lives of property, plant and equipment are reassessed annually at financial year end.

f) Capital Work in Progress

Capital work in progress is not depreciated. The total cost of a project is transferred to buildings, building fitout and/or plant and equipment on its completion and then depreciated.

g) Leased Assets

Leases where Nelson Marlborough DHB assumes substantially all the risks and rewards of ownership are classified as finance leases. The assets acquired by way of finance lease are stated at an amount equal to the lower of their fair value or the present value of minimum lease payments.

h) Disposal of Property, Plant and Equipment

When Property, Plant and Equipment is disposed of, any gain or loss is recognised in the surplus or deficit and is calculated as the difference between the net sale price and the carrying value of the asset.

When revalued assets are sold, the amounts included in revaluation reserves in respect of those assets are transferred to general funds.

PROVISIONS

Nelson Marlborough DHB recognises a provision for future expenditure of uncertain amount or timing when there is a present legal or constructive obligation as a result of a past event, it is probable that an outflow of economic benefits will be required to settle the obligation and a reliable estimate can be made of the amount of the obligation.

Provisions are measured at the present value of the expenditures expected to be required to settle the obligation. Provisions are not discounted if the effect of the time value of money is not material.

a) Restructuring

A provision for restructuring is recognised when Nelson Marlborough DHB has approved a detailed and formal restructuring plan, and the restructuring has either commenced or has been announced publicly. Future operating costs are not provided for.

b) ACC Partnership Programme

Nelson Marlborough DHB belongs to the ACC Partnership Programme under which it accepts the management and financial responsibility for employee work-related illnesses and accidents. Under the programme, Nelson Marlborough DHB is liable for all its claims costs for a period of four years up to a specified maximum. At the end of the four year period, Nelson Marlborough DHB pays a premium to ACC for the value of residual claims, and from that point the liability for ongoing claims passes to ACC.

The liability for the ACC Partnership Programme is measured using actuarial techniques at the present value of expected future payments to be made in respect of the employee injuries and claims up to balance date. Consideration is given to anticipated future wage and salary levels and experience of employee claims and injuries.

Expected future payments are discounted at a rate that approximates the average gross yield on Government Bonds of short to medium term durations consistent with the duration of the liabilities.

REVENUE

Revenue is measured at the fair value of consideration received or receivable.

a) Crown Funding

The majority of revenue is provided through an appropriation in association with a Crown Funding Agreement. Revenue is recognised monthly in accordance with the Crown Funding Agreement payment schedule, which allocates the appropriation equally throughout the year.

b) ACC Contracted Revenue

ACC contract revenue is recognised as revenue when eligible services are provided and any contract conditions have been fulfilled.

c) Inter-District Patient Flows

Inter district patient inflow revenue occurs when a patient treated within the Nelson Marlborough DHB region is domiciled outside of the region. The Ministry of Health credits Nelson Marlborough DHB with a monthly amount based on estimated patient treatment of non-Nelson Marlborough residents. An annual wash up occurs at year end of reflect the actual non-Nelson Marlborough patients treated at Nelson Marlborough DHB.

d) Rental Income

Lease income under an operating lease is recognised as revenue on a straight-line basis over the lease term.

e) Goods Sold

Revenue from goods sold is recognised when Nelson Marlborough DHB has transferred to the buyer the significant risks and rewards of ownership of the goods and Nelson Marlborough DHB does not retain either continuing managerial involvement to the degree usually associated with ownership or effective control over the goods sold.

f) Provision of Services

Revenue from services is recognised, to the proportion that a transaction is complete, when it is probable that the payment associated with the transaction will flow to Nelson Marlborough DHB and that payment can be measured or estimated reliably, and to the extent that any obligations and all conditions have been satisfied by Nelson Marlborough DHB.

g) Interest Income

Interest income is recognised using the effective interest method.

h) Donated Assets

Where a physical asset is gifted to or acquired by Nelson Marlborough DHB for nil or nominal cost, the fair value of the asset received is recognised as income. Such assets are recognised as income when control over the asset is obtained.

i) Volunteer Services

Certain operations of Nelson Marlborough DHB are reliant on services provided by volunteers. Volunteer services received are not recognised as revenue or expenditure by Nelson Marlborough DHB due to the difficulty of measuring their fair value with reliability.

j) Trust and Bequest Funds

Donations and bequests are made for specific purposes. The use of these funds must comply with the specific terms of the sources from which the funds were derived.

All donations and bequests are assigned to and managed by the Nelson Marlborough Hospitals Charitable Trust (NMHCT) which has an independent Board of Trustees. The funds are held separately by NMHCT and not included in NMDHB's Statement of Financial Position. The revenue and expenditure in respect of these funds are also excluded from NMDHB 's surplus or deficit.

Donations and bequests to the Nelson Marlborough DHB from the NMHCT are recognised as income when received, or entitlement to receive money is established. Expenditure subsequently incurred in respect of these funds is recognised as an expense in the surplus or deficit.

4. REVENUE

	PARENT & GROUP	
	2014 Actual $000	**2013 Actual $000**
Health and Disability Services (MOH contracted revenue)	407,185	395,504
Inter District Patient Inflows	7,818	8,259
ACC	4,820	4,133
Patient/Consumer Sourced Revenue	6,155	5,767
Other Government and DHB's	1,383	1,270
	427,360	**414,933**

Nelson Marlborough DHB has been provided with funding from the Crown for specific purposes of the DHB as set out in its founding legislation and the scope of the relevant government appropriations. Apart from these general restrictions, there are no unfulfilled conditions or contingencies attached to government funding (2013: $Nil).

5. OTHER OPERATING INCOME

	PARENT & GROUP	
	2014 Actual $000	**2013 Actual $000**
Donated Property, Plant & Equipment	200	46
Rental income	1,440	1,155
Gain on Disposal of Property, Plant & Equipment	235	13
Other income	2,759	2,522
	4,634	**3,736**

6. FINANCE INCOME & COSTS

	Parent & Group	
	2014 Actual $000	**2013 Actual $000**
Interest income	2,180	1,767
Finance Income	2,180	1,767
Interest on finance lease	255	82
Interest on loans	2,876	2,844
Interest on overdraft	-	-
Finance costs	**3,131**	**2,926**

7. PERSONNEL COSTS

	PARENT & GROUP	
	2014 Actual $000	**2013 Actual $000**
Wages and salaries	144,959	142,298
Contributions to defined contribution plans	4,425	3,587
Other personnel costs	6,721	7,321
	156,105	**153,206**

8. OTHER OPERATING EXPENSES

	Note	PARENT & GROUP 2014 Actual $000	PARENT & GROUP 2013 Actual $000
Audit fees - Annual Audit		165	147
Donations made		-	-
Koha		0	1
Impairment loss on property, plant and equipment		-	-
Impairment of receivables (bad and doubtful debts)		91	107
Loss on disposal of property, plant and equipment		136	1
Rental and operating lease costs		2,164	2,111
Restructuring expenses		-86	201
		2,470	**2,568**

During the year, Nelson Marlborough Hospitals Charitable Trust paid audit fees of $3,117 (2013: $3,559).

9. CAPITAL CHARGE

Nelson Marlborough DHB pays a six monthly Capital Charge to the Crown based on the greater of its actual or budgeted closing equity balance for the month.
The capital charge rate for the year ended 30 June 2014 was 8% (2013: 8%).

10. CASH & CASH EQUIVALENTS

	PARENT & GROUP 2014 Actual $000	PARENT & GROUP 2013 Actual $000
Bank Balances & cash on hand	7	(7)
Funds advanced to HBL	45,443	30,452
Cash and cash equivalents in the Statement of Cash Flows	**45,450**	**30,445**

Nelson Marlborough DHB is a party to the "DHB Treasury Services Agreement" between Health Benefits Limited (HBL) and the participating DHBs. This Agreement enables HBL to "sweep" DHB bank accounts and invest surplus funds. The DHB Treasury Services Agreement provides for individual DHBs to have a debit balance with HBL, which will incur interest at the credit interest rate received by HBL plus an administrative margin. The maximum debit balance that is available to any DHB is the value of provider arm's planned monthly Crown revenue, used in determining working capital limits, is defined as one-12th of the annual planned revenue paid by the funder arm to the provider arm as denoted in the most recently agreed Annual Plan inclusive of GST. For Nelson Marlborough DHB that equates to $20M.

The balance held by NMDHB within this Agreement is shown within the table above.

The carrying value of bank balances and cash on hand, funds advanced to HBL, call deposits, and term deposits with maturities less than three months approximate their fair value.

As at 30 June 2014, Nelson Marlborough DHB did not have any call deposits. As at 30 June 2013, Nelson Marlborough DHB did not have any call deposits.

11. DEBTORS AND OTHER RECEIVABLES

	PARENT & GROUP	
	2014 Actual $000	2013 Actual $000
Trade receivables due from non-related parties	1,761	1,329
Ministry of Health receivables	3,346	3,615
Gross trade receivables	5,107	4,944
Less Provision for impairment	(387)	(420)
Net trade receivables	4,720	4,524
Accrued Income	6,299	6,422
Other Receivables	38	24
Total debtors and other receivables	**11,056**	**10,970**

Fair Value

Trade and other receivables are non-interest bearing and receipt is normally on 30-day terms, therefore the carrying value of trade and other receivables approximates their fair value.

Impairment

As at 30 June 2014 and 2013, all overdue receivables have been assessed for impairment and appropriate provisions applied, as detailed below:

	PARENT & GROUP			
	Gross Receivable 2014 $000	Impairment 2014 $000	Gross Receivable 2013 $000	Impairment 2013 $000
Trade Receivables				
Current	4,112	(18)	3,571	(14)
31-60 days	244	(4)	239	(1)
61-90 days	155	(3)	375	(8)
Over 90 days	596	(362)	759	(397)
Total	**5,107**	**(387)**	**4,944**	**(420)**

All receivables greater than 30 days in age are considered to be past due.

The impairment provision has been calculated based on expected losses. Expected losses are determined by specific review of Ministry of Health receivables, and based on an analysis of Nelson Marlborough DHB's losses during previous periods for other trade receivables.

In summary, trade receivables are determined to be impaired as follows:

	PARENT & GROUP	
	2014 Actual $000	2013 Actual $000
Gross trade receivables	5,107	4,944
Individual impairment	-	-
Collective impairment	(387)	420)
Net trade receivables	**4,720**	**4,524**

Movements in the provision for impairment of receivables are as follows:

	PARENT & GROUP	
	2014 Actual $000	2013 Actual $000
Provision for impairment at 1 July	420	421
Additional provisions made during the year	91	107
Provisions used during the year	(124)	(108)
Provisions reversed during the period	-	-
Provision for impairment at 30 June	**387**	**420**

Nelson Marlborough DHB does not hold any collateral as security or other credit enhancements over receivables that are either past due or impaired.

12. INVENTORIES

	PARENT & GROUP	
	2014 Actual $000	2013 Actual $000
Inventories held for distribution		
- Pharmaceuticals	402	341
- Other Supplies net of provision for obsolete stock.	1,769	1,707
	2,171	**2,048**

In 2014, the value of inventories distributed and recognised as an expense in the clinical supplies expense included in the deficit was $17.9 million (2013 $17.7 million).

The carrying amount of inventories held for distribution carried at current replacement cost at 30 June 2014 is $Nil (2013 $Nil). The write-down of inventories held for distribution amounted to $Nil for 2014 (2013 $Nil). There have been no reversals of write-downs (2013: $Nil).

No inventories are pledged as security for liabilities nor are any inventories subject to retention of title clauses.

13. NON-CURRENT ASSETS FOR SALE

13a. Non-Current Assets Held for Sale

	PARENT & GROUP	
	2014 Actual $000	2013 Actual $000
Non-current assets held for sale include:		
- Land	-	958
- Buildings	-	3,173
	-	4,131

13b. Non-Current Assets Being Prepared for Sale

	PARENT & GROUP	
	2014 Actual $000	2013 Actual $000
Non-current assets held for sale include:		
- Land	418	-
- Buildings	333	-
	751	**-**

Nelson Marlborough DHB owns 4 properties in Nelson and Murchison which have been classified as being prepared for sale following the Board approval to sell the properties, as they will provide no future use to Nelson Marlborough DHB. The accumulated property revaluation reserve recognised in equity in relation to these properties is $323,373.

14. OTHER FINANCIAL ASSETS

	PARENT & GROUP	
	2014 Actual $000	2013 Actual $000
Shares in South Island Shared Services Agency Limited	3	3
Other Investments (Loans)	2,338	-
	2,341	**3**

Nelson Marlborough District Health Board owns shares in the South Island Shared Services Agency Limited (SISSAL). SISSAL is an agency set up by all South Island DHBs to provide shared support services.

The shares have been recorded at cost as they do not have a quoted price in an active market and their fair value cannot be reliably measured.

In September 2013 Nelson Marlborough entered into two loans with Golden Bay Integrated Health Centre (GBIFHC). The first loan is for $1,560,000, repayable over 25 years, interest free for 5 years. The second loan is for $778,000, repayable over 35 yearsbut not before 25 years.

There are no impairment provisions for other financial assets in 2014 (2013: $Nil).

15. PROPERTY, PLANT & EQUIPMENT

	PARENT & GROUP						
	Land	Buildings	Plant & Equipment	Motor Vehicles	Leased Assets	Work in Progress	Total
	$000	$000	$000	$000	$000	$000	$000
Cost or Valuation							
Balance at 1 July 12 - at Valuation	12,416	130,587	-	-	-	-	143,003
Balance at 1 July 12 - at Cost	-	3,155	46,510	5,296	9,646	2,311	66,918
Additions	140	2,688	2,789	316	578	5,901	12,412
Revaluation increase/(decrease)	55	233	-	-	-	-	288
Impairment Loss	-	(3,773)	-	-	-	-	(3,773)
Disposals/transfers	-	(1,189)	(4,986)	(174)	(41)	(6,537)	(12,927)
Balance at 30 June 13 - at Valuation	12,471	127,047					139,518
Balance at 30 June 13 - at Cost	**140**	**4,654**	**44,313**	**5,438**	**10,182**	**1,676**	**66,403**
Balance at 1 July 13 - at Valuation	12,471	127,047	-	-	-	-	139,518
Balance at 1 July 13 - at Cost	140	4,654	44,313	5,438	10,182	1,676	66,403
Additions	-	1,214	1,687	244	9,008	12,493	24,646
Revaluation increase/(decrease)	-	-	-	-	-	-	-
Impairment Loss	-	-	-	-	-	-	-
Disposals/transfers	(690)	(294)	(114)	(209)	(5)	(12,151)	(13,463)
Balance at 30 June 14 - at Valuation	**11,781**	**126,753**					**138,534**
Balance at 30 June 14 - at Cost	**140**	**5,868**	**45,886**	**5,473**	**19,185**	**2,018**	**78,570**

-

Accumulated Depreciation & Impairment Losses							
Balance at 1 July 12	-	324	31,958	3,444	7,770	-	43,496
Depreciation for the year	-	5,569	3,524	485	1,128	-	10,707
Revaluations / Impairment Loss	-	25	-			-	25
Disposals/transfers	-	(328)	(5,067)	(144)	(40)	-	(5,579)
Balance at 30 June 13	-	5,591	30,415	3,785	8,858	-	48,649
Balance at 1 July 13	-	5,591	30,415	3,785	8,858	-	48,649
Depreciation for the year	-	5,553	3,377	422	1,058	-	10,410
Revaluations / Impairment Loss	-	-	-			-	-
Disposals/transfers	-	(34)	(113)	(181)	(5)	-	(333)
Balance at 30 June 14	**-**	**11,110**	**33,679**	**4,026**	**9,911**	**-**	**58,726**
Carrying Amounts							
At 1 July 12	12,416	133,418	14,552	1,852	1,876	2,311	166,425
At 30 June 13	12,611	126,110	13,898	1,653	1,324	1,676	157,272
At 1 July 13	12,611	126,110	13,898	1,653	1,324	1,676	157,272
At 30 June 14	**11,921**	**121,511**	**12,207**	**1,447**	**9,274**	**2,018**	**158,378**

Impairment

No impairment loss was recognised in 2014 (2013: $3.8m Impairment Loss recognised, this arose primarily due to modifications required to buildings to meet earthquake standards ($2.5m), reduction in Golden Bay Hospital asset ($0.3m) and roof repair ($1.0m).

Revaluation

The most recent revaluation of land and buildings was carried out as at 30 June 2012 by M Lauchlan, a registered valuer with Duke & Cooke Limited. An optimised depreciated replacement cost methodology has been used. The revaluation excluded buildings purchased during that year. All other items of property, plant and equipment are recorded on a historical cost basis. The carrying amount of property, plant and equipment is not materially different to its fair value. The next revaluation will be completed by 30 June 2015

All other items of property, plant and equipment are recorded on a historical cost basis.
The carrying amount of property, plant and equipment is not materially different to its fair value.

Restrictions

Nelson Marlborough DHB does not have full title to Crown land it occupies but transfer is arranged if and when land is sold. Some of the land is subject to Waitangi Tribunal claims. The disposal of certain properties may be subject to the provisions of section 40 of the Public Works Act 1981.

Titles to land transferred from the Crown to Nelson Marlborough DHB are subject to a memorial in terms of the Treaty of Waitangi Act 1975 (as amended by the Treaty of Waitangi (State Enterprises) Act 1998). The effect on the value of assets resulting from potential claims under the Treaty of Waitangi Act 1975 cannot be quantified.

Leased Assets

Nelson Marlborough DHB leases clinical and IT equipment under a number of finance lease agreements. At 30 June 2014, the net carrying amount of leased IT and clinical equipment was $1,075,698 (2013: $1,324,235).

Work In Progress

The total amount of property, plant, and equipment in the course of construction is $2.02m (2013: $1.68m).

16. INTANGIBLE ASSETS

(a) Software

	PARENT & GROUP			
	Owned	Leased	Work in Progress	Total
	$000	$000	$000	$000
Balance at 1 July 12 - at Cost	6,838	331	83	7,252
Additions	1,372	-	1,525	2,897
Disposals/transfers	(224)	(65)	(1,343)	(1,632)
Balance at 30 June 13 - at Cost	7,985	266	265	8,516
Balance at 1 July 13 - at Cost	7,985	266	265	8,516
Additions	334	-	1,328	1,662
Disposals/transfers	-	-	(334)	(334)
Balance at 30 June 14 - at Cost	**8,319**	**266**	**1,259**	**9,844**
Accumulated Amortisation & Impairment Losses				
Balance at 1 July 12	5,082	330	-	5,412
Amortisation for the year	698	-	-	698
Impairment Loss	-	-	-	-
Disposals	(224)	(65)	-	(289)
Balance at 30 June 13	**5,556**	**265**	**-**	**5,821**
Balance at 1 July 13	5,556	265	-	5,821
Amortisation for the year	783	-	-	783
Impairment Loss	-	-	-	-
Disposals	-	-	-	-
Balance at 30 June 14	**6,339**	**265**	**-**	**6,604**
Carrying Amounts				
At 1 July 12	1,756	1	83	1,840
At 30 June 13	2,430	1	265	2,696
At 1 July 13	2,430	1	265	2,696
At 30 June 14	**1,981**	**1**	**1,259**	**3,241**

(b) Health Benefits Limited Finance, Procurement and Supply Chain Investment

	PARENT & GROUP	
	2014 Actual	2013 Actual
	$000	$000
Balance at 1 July 13 - at Cost	906	-
Additions	546	906
Balance at 30 June 14 - at Cost	**1,452**	**906**

During the year shares were purchased in Health Benefits Limited (HBL). HBL is an agency set up by all the Ministry of Health to provide shared services for District Health Boards. The investment was made to fund the establishment of a shared service arrangement to support the delivery of Finance, Procurement and Supply Chain services.

The shares have been recorded at cost as they do not have a quoted price in an active market and their fair value cannot be reliably measured.

At 30 June 2014, the DHB had made payments totalling $1,452,420 (2013: $906,120) to HBL in relation to the FPSC Programme, which was in progress at year end. This is a national initiative facilitated by HBL. In return for these payments, the DHB gains FPSC rights. In the event of liquidation or dissolution of HBL, the DHB shall be entitled to be paid from the surplus assets, an amount equal to, the DHB's proportionate share of the liquidation value based on its proportional share of the total FPSC rights that have been issued.

These FPSC rights have been tested for impairment by comparing the carrying amount of the intangible asset to its depreciated replacement cost (DRC), which is considered to equate to the DHB's share of the DRC of the underlying FPSC assets.

It is expected that the final costs of the FPSC Programme will exceed the original budget. HBL is undertaking an exercise to determine the revised costs of the programme and following this, formal approval to proceed will be required from the DHBs. The current expectation of the Board is that the FPSC Programme will proceed as originally planned. In this scenario, the DRC of the FPSC assets is considered to equate, in all material respects, to the costs capitalised to date such that the FPSC rights are not impaired. However, the future of the FPSC Programme is uncertain and any future decision to re-scope or discontinue the FPSC Programme will require a reassessment of the recoverable amount (i.e. DRC) of the FPSC rights.

	PARENT & GROUP	
	2014 Actual $000	**2013 Actual $000**
Total Intangible Assets		
Carrying Amounts		
(a) Software	2,696	1,840
(b) Health Benefits Limited Finance, Procurement and Supply Chain Investment	906	-
Total Intangible Asset Balance at 1 July 2013 - at Cost	3,602	1,840
(a) Software	3,241	2,696
(b) Health Benefits Limited Finance, Procurement and Supply Chain Investment	1,452	906
Total Intangible Asset Balance at 30 June 2014 - at Cost	**4,693**	**3,602**

IMPAIRMENT

No impairment losses have been recognised (2013: $Nil).

LEASED INTANGIBLES

Nelson Marlborough DHB leases IT software under a number of finance lease agreements. At 30 June 2014, the net carrying amount of leased intangibles was $212 (2013: $342).

17. CREDITORS AND OTHER PAYABLES

	PARENT & GROUP	
	2014 Actual $000	**2013 Actual $000**
Trade payables	5,114	2,587
Revenue in advance	651	802
Capital Charge payable	-	-
GST, PAYE & FBT payable	3,818	4,006
Other non-trade payables and accrued expenses	18,258	15,781
	27,841	**23,175**

Trade and other payables are non-interest bearing and are normally settled on 30-day terms, therefore the carrying value of trade and other payables approximates their fair value.

18. LOANS & BORROWINGS

	PARENT & GROUP	
	2014 Actual $000	2013 Actual $000
Current		
Current portion of Debt Management Office fixed interest loans	8,000	10,500
Current portion of finance lease liabilities	765	641
	8,765	11,141
Non-current		
Debt Management Office fixed interest loans	47,500	45,000
Finance lease liabilities	8,145	252
	55,645	**45,252**

(a) Debt Management Office fixed interest loans

Nelson Marlborough District Health Board has ten loans with the Debt Management Office. The terms and conditions are as follows:

	PARENT & GROUP	
Interest rate summary	2014 Actual	2013 Actual
Debt Management Office (%)	4.13% - 6.535%	2.91% - 6.535%

The interest rates on the seven loans are fixed.

	PARENT & GROUP	
Loans are repayable as follows:	2014 Actual $000	2013 Actual $000
Within next 12 months	8,000	10,500
One to two years	6,000	8,000
Two to five years	25,000	21,000
Beyond five years	16,500	16,000
	55,500	**55,500**

	PARENT & GROUP	
Term Loan Facility Limits	2014 Actual $000	2013 Actual $000
Debt Management Office	**55,500**	**55,500**

SECURITY AND TERMS

Theses loans were previously provided by the Crown Health Funding Authority however this entity no longer exists. The loan facility is now provided by the Debt Management Office, which is part of the Treasury and administered by the Ministry of Health. The Debt Management Office term liabilities are secured by a negative pledge.

Without the Debt Management Office's prior written consent Nelson Marlborough DHB cannot perform the following actions:

- Create any security interest over its assets except in certain defined circumstances; or
- Lend money to another person or entity (except in the ordinary course of business and then only on commercial terms)
- or give a guarantee; or
- Make a substantial change in the nature or scope of its business as presently conducted or undertake any business or activity unrelated to health; or
- Dispose of any of its assets except at full value in the ordinary course of business. Term loans are not guaranteed by the Government of New Zealand.

(b) Finance Lease Liabilities

Finance Leases are repayable as follows:

	Minimum lease payments	Interest	Principal	Minimum lease payments	Interest	Principal
	2014	2014	2014	2013	2013	2013
	$000	$000	$000	$000	$000	$000
Within next 12 months	1,043	279	764	672	31	641
One to two years	688	256	432	223	6	216
Two to five years	1,481	757	724	37	1	36
Beyond five years	14,350	7,361	6,989	-	-	-
	17,562	**8,653**	**8,909**	**932**	**39**	**893**

Description of Material Leasing Arrangements

Nelson Marlborough DHB has entered into finance leases primarily for IT equipment, and for certain items of clinical equipment. The net carrying amount of the leased items within each class of property, plant and equipment, and intangible assets is shown in notes 15 & 16.

In September 2013 Nelson Marlborough DHB set up a finance lease to account for the lease of the completed Golden Bay Integrated Health Centre facilities to the Golden Bay Community Health Trust. The initial terms had a Net Present Value of $8,386,915, a discount rate of 4.75% and a term of 35 years. As at 30 June 2014, Golden Bay Community Health Trust had an outstanding lease liability with a present value of $8,187,227.

Nelson Marlborough DHB does not have the option to purchase the asset at the end of the lease term.

There are no restrictions placed on Nelson Marlborough DHB by any of the finance leasing arrangements.

19. EMPLOYEE ENTITLEMENTS

	PARENT & GROUP	
	2014 Actual $000	2013 Actual $000
Current liabilities		
Sabbatical leave	196	196
Retirement Gratuities	1,588	1,537
Long service leave	576	558
Annual leave	16,415	15,704
Sick Leave	383	444
Continuing medical education	6,904	7,014
Salary and wages accrued	4,833	4,254
	30,895	**29,707**
Non-current liabilities		
Sick Leave	705	763
Sabbatical leave	1,353	1,374
Retirement Gratuities	6,306	6,653
Long service leave	2,543	2,671
	10,907	**11,461**

The present value of the long service leave, retirement gratuities, sabbatical leave, and sick leave obligations depend on a number of factors that are determined on an actuarial basis. The key assumptions used in calculating these liabilities are the discount rate, salary inflation factor, resignation rate, and take-up rate (for sabbatical leave). Any changes in these assumptions will impact on the carrying amount of the liability.

LONG SERVICE LEAVE, RETIREMENT GRATUITIES, AND SABBATICAL LEAVE

The discount rates used are the risk free rates as determined by the NZ Treasury and published on its website. Discount rates used range from 3.42% to 5.5% (2013: 2.53-6.00%), with an average of 4.85% (2013: 4.57%). For SMOs, a salary inflation factor of 3.5% (2013: 3.0%) has been used per year. For non-SMOs, a salary inflation factor of 3.5% has been used in all years (2013: 3.0%). The take-up rate used for sabbatical leave is 25% (2013: 25%).

The valuation is most sensitive to changes in the assumed interest rate, salary inflation factor, and resignation rates. A 1% increase/decrease in the salary inflation factor would, leaving all other assumptions unaltered, result in a $668,000 increase/$606,000 decrease in the long service leave, retirement gratuities and sabbatical leave liability (2013: $706,000 increase / $642,000 decrease).

SICK LEAVE

The discount rates used in the valuation are the risk free rates as determined by the NZ Treasury and published on its website. The average discount rate is 4.3% (2013: 3.6%). Average future salary growth has been assumed to be 3.5% per annum, plus a salary scale of 1% per annum.

20. PROVISIONS

	PARENT & GROUP	
	2014 Actual	2013 Actual
Current Provisions	$000	$000
Restructuring	691	1,067
ACC Partnership Programme	363	363
	1,054	1,430
Total Provisions	1,054	1,430

Movements in Provisions	PARENT & GROUP		
	Restructuring	ACC Partnership Programme	Total
2013	$000	$000	$000
Balance at 1 July 2012	25	363	388
Additional provisions made during the year	1,067	-	1,067
Provisions used during the year	(25)	-	(25)
Provisions reversed during the period	-	-	-
Balance at 30 June 2013	1,067	363	1,430
2014			
Balance at 1 July 2013	1,067	363	1,430
Additional provisions made during the year	500	-	500
Provisions used during the year	(735)	-	(735)
Provisions reversed during the period	(141)	-	(141)
Balance at 30 June 2014	691	363	1,054

RESTRUCTURING PROVISIONS

An amount of $0.74m has been released from the provision in relation to completed restructuring initiatives, and revisions to the estimated redundancy costs for initiatives not yet completed. (2013: $0.03m)

ACC Partnership Programme

LIABILITY VALUATION

The liability for the ACC Partnership Programme is measured at the present value of anticipated future payments to be made in respect of the employee injuries and claims up to the reporting date using actuarial techniques. Consideration is given to expected future wage and salary levels, and experience of employee claims and injuries.

Expected future payments are discounted using a rate that approximates the average gross yield on Government Bonds of short to medium term durations consistent with the duration of the liabilities.

An external independent actuarial valuer, Marcelo Lardies (BSc (Hons), Fellow of the NZ Society of Actuaries) from Aon New Zealand Limited, has calculated the DHB's liability, and the last valuation was effective at 30 June 2014. The valuer has attested he is satisfied as to the completeness and accuracy of the data used to determine the outstanding claims liability. There are no qualifications contained in the actuarial valuer's report.

RISK MARGIN

A risk margin of 11% has been included allow for the inherent uncertainty in the central estimate of the claims liability. This is the rate used by ACC.

Pre valuation date claim inflation has been taken as 50% of movements in the Consumer Price Index and 50% of the movements in the Average Wage Earnings index. Post valuation date claim inflation has been taken as 3.5% per annum. The discount rate used is 4.3% per annum (2013: 3.5%).

The value of the liability is not material for the DHB's financial statements. Therefore, any changes in the assumptions will not have a material impact on the financial statements.

INSURANCE RISK

Nelson Marlborough DHB operates the Full Self Cover Plan. Under this plan, it assumes full financial and injury management responsibility for work-related injuries and illnesses for a selected management period and continuing financial liability for the life of the claim to a pre-selected limit.

The DHB is responsible for managing claims for a period of up to 48 months following the lodgement date. At the end of 48 months, if an injured employee is still receiving entitlements, the financial and management responsibility of the claim will be transferred to ACC for a price calculated on an actuarial valuation basis.

Nelson Marlborough DHB has chosen a stop loss limit of 160% of the industry premium and a stop loss limit of $250,000 for any high cost claim.

Nelson Marlborough DHB is not exposed to any significant concentrations of insurance risk as work related injuries are generally the result of an isolated event to an individual employee.

21. EQUITY

	PARENT & GROUP	
	2014 Actual $000	**2013 Actual $000**
(a) Crown Equity		
Balance at 1 July	29,134	29,681
Equity Injections	-	-
Equity Repayments	(547)	(547)
Balance at 30 June	**28,587**	**29,134**
(b) Retained Earnings		
Balance at 1 July	10,289	13,219
Net (deficit)/surplus	4,392	(2,930)
Transfer from property, plant and equipment revaluation reserve on classification as held for sale	-	-
Transfer from property, plant and equipment revaluation reserve on disposal		-
Retained Earnings at 30 June	**14,681**	**10,289**

(c) Revaluation Reserve		
Opening Balance at 1 July	47,423	50,988
Revaluations of Land and Buildings	-	-
Impairment Charge	-	(3,565)
Transfer to Retained Earnings on classification as held for sale	-	-
Transfer to Retained Earnings on disposal of property, plant and equipment	(449)	-
Balance at 30 June	**46,974**	**47,423**
Revaluation reserves consist of:		
Land	8,928	9,004
Buildings	38,046	38,419
Total Revaluation Reserves	**46,974**	**47,423**
Total Equity at 30 June	**90,242**	**86,846**

Retained earnings includes accumulated surpluses/deficits of unspent mental health ring fenced funding as detailed in note 30.

22. RECONCILIATION OF NET SURPLUS/(DEFICIT) WITH NET CASH FLOW FROM OPERATING ACTIVITIES

	PARENT & GROUP	
	2014 Actual $000	**2013 Actual $000**
Reported surplus/(deficit)	4,392	(2,930)
Add back non-cash items:		
Depreciation and amortisation expense	11,193	11,404
Impairment losses	-	-
Add back items classified as investing activities:		
Net Loss/(Gain) on disposal of Property, Plant & Equipment	(100)	(12)
Movements in working capital:		
(Increase)/Decrease in debtors and other receivables	(86)	1,843
(Increase)/Decrease in prepayments	31	(92)
(Increase)/Decrease in inventories	(123)	198
Increase/(Decrease) in creditors and other payables	4,666	824
Increase/(Decrease) in employee entitlements	634	(698)
Increase/(Decrease) in provisions	(376)	1,042
Movements in working capital disclosed as investing activities:		
(Increase)/Decrease in creditors relating to purchase of Property, Plant & Equipment	99	2
(Increase)/Decrease in Deferred Gain on sale and leaseback of Property, Plant & Equipment		
Net cash (outflow)/inflow from operating activities	**20,332**	**11,582**

23. OPERATING LEASES

(a) Leases as lessee	PARENT & GROUP 2014 Actual $000	2013 Actual $000
The future aggregate minimum lease payments to be paid under non-cancellable operating leases are as follows:		
Less than one year	653	701
Between one and five years	1,802	1,725
More than five years	1,393	1,693
Total non-cancellable operating leases	**3,848**	**4,119**

Nelson Marlborough DHB leases several buildings under operating leases. The leases are for periods ranging from 1 to 7 years initially, with rights of renewal ranging from 1 to 6 years.

The DHB also leases clinical equipment under operating leases. The lease terms are for periods ranging from 18 months to 2 years.

There are no restrictions placed on Nelson Marlborough DHB by any of its leasing arrangements.

During the year ended 30 June 2014, $2,163,713 was recognised as an expense in the surplus or deficit in respect of operating leases (2013: $2,110,926)

(b) Leases as lessor

Nelson Marlborough DHB leases owned properties to third parties under operating leases resulting in revenue of $1.3m (2013: $1.0m). These leases are for periods ranging initially from 2 to 99 years. In some cases, rights of renewal for one or more terms ranging from 2 to 5 years are provided. Some leases are subject to the terms of service contracts.

	PARENT & GROUP 2014 Actual	2013 Actual
The future minimum lease payments under non-cancellable operating leases in the aggregate and for each of the following periods:	**$000**	**$000**
Not later than one year	1,307	770
Later than one year and not later than five years	2,897	1,364
Later than five years	3,319	-
	7,523	**2,133**

NMDHB have entered into a sub-lease with Nelson Bays Primary Health Organisation for the Golden Bay Integrated Health Centre buildings. The sub lease is for an initial amount of $492,000 plus GST per annum, commencing 16 September 2013, for a term of 10 years with a two yearly rent review.

24. FINANCIAL INSTRUMENTS

Nelson Marlborough DHB is party to financial instruments as part of its everyday operations. These include instruments such as bank balances, accounts receivable, trade creditors and loans.

Nelson Marlborough DHB has a series of policies providing risk management for interest rates and the concentration of credit. The policies do not allow any transactions which are speculative in nature to be entered into.

From 1 July 2012 Health Benefits Limited (HBL) assumed responsibility for the investment of all the Nelson Marlborough DHB's surplus funds. The policies risk mamagement policies HBL have adopted are consistent with the those that follow.

a) Interest rate risk

Interest rate risk is the risk that the interest component of a financial instrument will fluctuate due to changes in market rates. This could particularly impact on the costs of borrowing or the return from investments.

The Board does not consider there is any significant exposure to interest rate risk on its investments.

The interest rates on the Board's borrowings are disclosed in Note 18.

There are no interest rate options or interest swap agreements in place as at 30 June 2014 (2013: $Nil).

b) Credit Risk

Credit risk is the risk that a third party will default on its obligations to Nelson Marlborough DHB, causing the DHB to incur a loss.

Financial instruments which potentially subject Nelson Marlborough DHB to credit risk principally consist of cash, short-term deposits and accounts receivable.

Concentrations of credit risk from accounts receivable are high due to the reliance on the Ministry of Health for approximately 94% of Nelson Marlborough DHB's revenue. However, the Ministry of Health is assessed to be a low risk and high-quality entity due to its nature as the government funded purchaser of health and disability support services.

Nelson Marlborough DHB is a party to the "DHB Treasury Services Agreement" between Health Benefits Limited (HBL) and the participating DHBs. HBL is a crown owned enity and in this capacity is assessed to be a low risk high-quality entity.

At balance date there were no significant other concentrations of credit risk. The maximum exposure to credit risk is represented by the carrying amount of cash and cash equivalents (note 10), and debtors and other receivables (note 11).

The credit quality of financial assets that are neither past due nor impaired can be assessed by reference to Standard and Poor's credit ratings (if available) or to historical information about counterparty default rates:

	PARENT & GROUP	
	2014 Actual $000	**2013 Actual $000**
Counterparties with Credit Ratings		
Cash and Cash Equivalents		
AA	-	-
Investments		
AA	-	-
Counterparties without Credit Ratings		
Cash and Cash Equivalents		
Cash on Hand	7	(7)
Funds Advanced to HBL	45,443	30,452
Debtors and Other Receivables		
Existing Counterparty with no defaults in the past	10,921	10,707
Existing Counterparty with defaults in the past	135	263
Total Debtors and Other Receivables	**11,056**	**10,970**

c) Currency Risk

Currency risk is the risk that the fair value or future cash flows of a financial instrument will fluctuate due to changes in foreign exchange rates.

Nelson Marlborough DHB had no foreign currency assets or liabilities as at 30 June 2014. During the year, expenditure invoiced in foreign currencies was recorded in NZD calculated with the same exchange rates as those used for the payments for those invoices. No exchange rate gains or losses were recorded.

d) Liquidity Risk

Liquidity risk represents Nelson Marlborough DHB's ability to meet its contractual obligations. The DHB evaluates its liquidity requirements on an ongoing basis by continuously monitoring forecast and actual cash flow requirements.

The following table sets out the contractual undiscounted cash flows for all financial liabilities.

	PARENT & GROUP						
2014	**Balance Sheet**	**Contractual cash flow**	**6 mths or less**	**6-12 mths**	**1-2 years**	**2-5 years**	**More than 5 years**
	$000	**$000**	**$000**	**$000**	**$000**	**$000**	**$000**
DMO loans	55,500	55,500	-	8,000	6,000	25,000	16,500
Finance lease liabilities	8,909	17,562	600	443	688	1,482	14,350
Creditors and other payables	23,372	23,372	23,372	-	-	-	-
Total	**87,781**	**96,434**	**23,972**	**8,443**	**6,688**	**26,482**	**30,850**
2013							
	$000	$000	$000	$000	$000	$000	$000
DMO loans	55,500	55,500	-	10,500	8,000	21,000	16,000
Finance lease liabilities	893	932	672	223	37	-	-
Creditors and other payables	18,368	18,368	18,368	-	-	-	-
Total	**74,761**	**74,800**	**19,040**	**10,723**	**8,037**	**21,000**	**16,000**

CAPITAL MANAGEMENT

Nelson Marlborough DHB's capital is its equity, which comprises Crown equity, reserves and retained earnings. Equity is represented by net assets.

Nelson Marlborough DHB is subject to the financial management and accountability provisions of the Crown Entities Act 2004, which impose restrictions in relation to borrowings, acquisition of securities, issuing guarantees and indemnities and the use of derivatives.

Nelson Marlborough DHB manages its equity as a by-product of prudently managing revenues, expenses, assets, liabilities and general financial dealings to ensure that it effectively achieves its objectives and purpose, whilst remaining a going concern.

There have been no material changes in Nelson Marlborough DHB's management of capital during the year.

e) Sensitivity Analysis

In managing interest rate risk, Nelson Marlborough DHB aims to reduce the impact of short-term fluctuations on its earnings. Over the longer term, however, permanent changes in interest rates would have an impact on earnings.

At 30 June 2014, it is estimated that a general increase of one percentage point in interest rates would decrease Nelson Marlborough DHB's deficit by approximately $454,000 (2013: $302,000).

f) Market Risk

Nelson Marlborough DHB does not have any significant market risk as it does not enter into derivative financial instruments.

g) Classification and Fair Values

The classification and fair values together with the carrying amounts shown in the Statement of Financial Position are as follows:

		PARENT & GROUP				
2014	**Note**	**Loans and receivables**	**Available for sale**	**Other - Amortised Cost**	**Carrying amount**	**Fair value**
Assets		**$000**	**$000**	**$000**	**$000**	**$000**
Cash and cash equivalents	10	45,450	-	-	45,450	45,450
Debtors and other receivables	11	11,056	-	-	11,056	11,056
Total Current assets		56,506	-	-	56,506	56,506
Other Financial Assets	14	2,338	3	-	2,341	2,341
Total Non-current assets		**2,338**	**3**	**-**	**2,341**	**2,341**
Total Assets		**58,844**	**3**	**-**	**58,847**	**58,847**
Liabilities						
Creditors and other payables	17	-	-	23,372	23,372	23,372
Finance lease liabilities	18	-	-	765	765	765
Secured loans	18	-	-	8,000	8,000	8,269
Total current liabilities		**-**	**-**	**32,137**	**32,137**	**32,406**
Finance lease liabilities	18	-	-	8,145	8,145	8,145
Secured loans	18	-	-	47,500	47,500	49,440
Total Non-current liabilities		-	-	55,645	55,645	57,585
Total Liabilities		**-**	**-**	**87,782**	**87,782**	**89,991**

2013	**Note**	**Loans and receivables**	**Available for sale**	**Other - Amortised Cost**	**Carrying amount**	**Fair value**
Assets		**$000**	**$000**	**$000**	**$000**	**$000**
Cash and cash equivalents	10	30,445	-	-	30,445	30,445
Debtors and other receivables	11	10,970	-	-	10,970	10,970
Investments		-	-	-	-	-
Total Current assets		**41,415**	**-**	**-**	**41,415**	**41,415**
Other Financial Assets	14	-	3	-	3	3
Total Non-current assets		-	3	-	3	3
Total Assets		**41,415**	**3**	**-**	**41,418**	**41,418**

Liabilities						
Creditors and other payables	17	-	-	18,368	18,368	18,368
Finance lease liabilities	18	-	-	641	641	641
Secured loans	18	-	-	10,500	10,500	10,675
Total current liabilities		**-**	**-**	**29,509**	**29,509**	**29,684**
Finance lease liabilities	18	-	-	252	252	252
Secured loans	18	-	-	45,000	45,000	48,470
Total Non-current liabilities		**-**	**-**	**45,252**	**45,252**	**48,722**
Total Liabilities		**-**	**-**	**74,761**	**74,761**	**78,406**

25. RELATED PARTY TRANSACTIONS & KEY MANAGEMENT PERSONNEL

Nelson Marlborough DHB is a wholly-owned entity of the Crown.

a) Significant transactions with government-related entities

The DHB has received funding from the Crown and ACC of $412.0m (2013: $399.8m) to provide health services in the Nelson Marlborough area for the year ended 30 June 2014.

Revenue earned from other DHBs for the care of patients outside Nelson Marlborough DHB's district amounted to $8.1m (2013: $8.3m) for the year ended 30 June 2014. Expenditure to other DHBs for their care of patients from Nelson Marlborough DHB's district amounted to $37.8m (2013: $40.2m) for the year ended 30 June 2014.

b) Collectively, but not individually, significant transactions with government-related entities

In conducting its activities, Nelson Marlborough DHB is required to pay various taxes and levies (such as GST, FBT, PAYE, and ACC levies) to the Crown and entities related to the Crown. The payment of these taxes and levies, other than income tax, is based on the standard terms and conditions that apply to all tax and levy payers. The DHB is exempt from paying income tax.

Nelson Marlborough DHB also purchases goods and services from entities controlled, significantly influenced, or jointly controlled by the Crown. Purchases from these government-related entities for the year ended 30 June 2014 totalled $2.8m (2013: $2.3m). These purchases included the purchase of electricity from Genesis Energy, air travel from Air New Zealand, and energy from Solid Energy.

c) Transactions with subsidiaries

Nelson Marlborough DHB entered into transactions with the Nelson Marlborough Hospitals Charitable Trust in the receipt of donations which are recognised as income when received, or an entitlement to receive money is established.

	Note	PARENT & GROUP	
		2014 Actual $000	**2013 Actual $000**
Donations from NMHCT		46	138
		46	138

Nelson Marlborough Hospitals Charitable Trust is recognised as a subsidiary of Nelson Marlborough DHB, however it's results are not deemed material and are not consolidated in these financial statements. 26

(d) Transactions with Key Management Personnel	PARENT & GROUP	
Key Management Personnel Remuneration	**2014 Actual $000**	**2013 Actual $000**
Salaries and other short-term employee benefits	4,714	4,456
Post-employment benefits	193	168
Other long-term benefits	-	-
Termination benefits	115	-
Total key management personnel remuneration	**5,022**	**4,624**

Key management personnel includes all Board members, the Chief Executive, and members of the Leadership Team.

Related party transactions involving key management personnel (or their close family members)

As disclosed above (Section (c)), the Nelson Marlborough DHB received donations from the NMHCT throughout the financial year. Both NMDHB Board Member Judy Crowe and NMDHB Chief Executive Chris Fleming have a significant influence over the NMHCT as the acting Chairperson and Trustee Member respectively. The funds of the NMCHT are managed by the NMCHT team which consists of an independent auditor, lawyer and Board of trustee members. This structure of NMCHT ensures that the transactions between NMDHB and the NMCHT occur on normal commercial terms and assists in retaining NMCHT's independence from the NMDHB. There are no outstanding ballances for unpaid invoices at year end.

The Nelson Marlborough DHB purchased services from Kimi Hauora Wairau PHO over the financial year. NMDHB Board Member Dawn McConnel is also a Board Member of Kimi Hauora Wairua PHO. Payments of $1.2m were made to Kimi Hauora Wairua PHO (2013: $1.3m). The transactions between NMDHB and Kimi Hauora Wairua PHO over the financial year occurred on normal commercial terms. There is a balance of $0.1m outstanding for unpaid invoices at year end.

The Nelson Marlborough DHB entered into a variety of transactions with Golden Bay Community Health Trust during the financial year. NMDHB's GM of Finance and Performance, Eric Sinclair and Board Secretary, Mike Cummins (Ceased employment with the NMDHB December 2014), are/were both Trustees of the Golden Bay Community Health Trust. The NMDHB has loaned $2.3m to the Golden Bay Community Health Trust and has an outstanding lease liability with a present value of $8.19m (Discount rate: 4.75%) at the end of the financial year. Lease payments to the Golden Bay Community Health Trust are expected to cease in the year 2048. The relationship of the lease and liability has been disclosed in Note 18(b). There are no outstanding ballances for unpaid invoices at year end.

Over the financial year, the Nelson Marlborough DHB had a variety of financial transactions with Health Benefits Limited. NMDHB's Chief Executive Chris Fleming, is a Director of Health Benefits Limited. Payments to Health Benefits Limited totalled $1.1m while receipts from Health Benefits Limited totalled $0.04m. The NMDHB purchased $0.5m worth of FPSC rights during the financial year, totalling the NMDHB's shareholding to $1.5m which reflects a 3.3% shareholding of Health Benefits Limited. The transactions during the financial year are consistent with the transition of Health Benefits Limited taking over New Zealand's DHB finance and procurement departments. There are no significant outstanding ballances for unpaid invoices at year end.

The Nelson Marlborough DHB purchased and received services from the Churchill Trust during the financial year. Chris Fleming, the NMDHB's Chief executive is a Trustee of the Churchill Trust. Revenue services from the Churchill Trust totalled $3.0m during the financial year, while payments to the Churchill Trust totalled $0.1m. The services provided for and from the Churchill Trust were on normal commercial terms. There is a balance of $0.2m outstanding for outstanding receipts at year end.

Over the financial year, the Nelson Marlborough DHB provided and purchased commercial services from Nelson Radiology Limited. NMDHB Board Member Stephen Busby is also a Director and minority shareholder of Nelson Radiology limited. Transactions during the financial year consisted of payments to Nelson Radiology Limited of $6.0m and revenue of $5.2m. All transactions were on normal commercial terms. There are no significant outstanding balances for unpaid invoices at year end.

During the year, the Nelson Marlborough DHB purchased services from the St Marks Society in Blenheim of which John Inder is a Board Member. The value of expenditure totalled $0.6m and was on normal commercial terms. There are no outstanding balance for unpaid invoices at year end.

Remuneration paid to Board members is disclosed separately in Note 33.

There are close family members of key management personnel employed by Nelson Marlborough DHB. The terms and conditions of those arrangements are no more favourable than the DHB would have adopted if there were no relationship to key management personnel.

26. NON CONSOLIDATION OF SUBSIDIARIES

Nelson Marlborough Hospitals Charitable Trust (the "Charitable Trust") provides health related services, projects, research, and education to the residents of the Nelson Marlborough District Health Board (the "DHB") catchment area. The Charitable Trust is controlled by the DHB in accordance with NZ IAS 27.

For the year ended 30 June 2014, the Trust had total revenue of $270,998 (2013: $119,210), and a net deficit of $95,347 (2013: Surplus $109,551). The Trust had assets of $3,025,768 (2013: $3,116,259), and liabilities of $Nil (2013: $Nil) at that date.

27. SUBSEQUENT EVENTS

The impacts of the announcement by Health Benefits Limited on proposed changes affecting back office services for DHBs, has not been assessed at the time of the adoption of these accounts.

Board members are not aware of any other matter or circumstance, since the end of the financial year (not otherwise dealt with in this report or in the Board's financial statements), that may significantly affect the operation of the organisation, the results of its operations, or the state of affairs of the Board.

28. ACCOUNTING ESTIMATES AND JUDGEMENTS

The estimates and judgements that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year are discussed below:

a) Property, plant and equipment useful lives and residual values

Nelson Marlborough DHB depreciates its property, plant and equipment over its useful life to its estimated residual value. An incorrect estimate of the useful life or residual value of an item of property, plant and equipment will impact the depreciation expense recognised in the surplus or deficit, and carrying amount of the asset in the Statement of Financial Position.

Nelson Marlborough DHB has not made any material changes to past assumptions concerning the useful lives and residual values of its property, plant and equipment. The carrying amounts of property, plant and equipment are disclosed in note 15.

b) Employee Entitlements

Long service leave, retiring leave, sabbatical leave, and sick leave liabilities are calculated on an actuarial basis. The key assumptions adopted in calculating the value of these liabilities are disclosed in note 19. Changes in these assumptions will have an impact of the carrying value of the liabilities.

c) Lease Classification

Determining whether a lease agreement is a finance lease or an operating lease requires judgement as to whether the agreement transfers substantially all the risks and rewards of ownership to Nelson Marlborough DHB. Judgement is required on various aspects that include the fair value of the leased asset, the economic life of the leased asset, whether or not to include renewal options in the lease term and determining an appropriate discount rate to calculate the present value of the minimum lease payments. Classification as a finance lease means the asset is recognised in the Statement of Financial Position as property, plant and equipment, whereas for an operating lease no such asset is recognised.

Nelson Marlborough DHB has exercised its judgement on the appropriate classification of equipment leases and has determined that a number of lease arrangements are finance leases.

d) Revenue Recognition

Nelson Marlborough DHB must exercise judgement where recognising revenue to determine if conditions of the contract have been satisfied. This judgement is based on the facts and circumstances that are evident for each grant contract.

29. EXPLANATION OF SIGNIFICANT VARIANCES FROM BUDGET

Significant variances from budget figures per the Statement of Intent are explained below:

a) Statement of Comprehensive Income

REVENUE

Revenue was favourable to Plan by $6.3m. A number of revenue lines accross the organisation contribute to this result with the lagest variances as follows:

» ACC revenue due to better capture of data and higher volume of ACC cases $1.1m

» Interest received $1.0m favourable to Plan

» Public Health Organisation Programmes for Heart and Diabetes checks, additional primary mental health AOD interventions, VLCA (Very Low Cost Access) and Careplus programmes were $0.6m favourable to Plan.

» Non-budgeted rental for Golden Bay Integrated Health Facility $0.5m

» Increased population based funding (PBFF) for green prescription, dementia and Home Based Support Services $0.4m favourable to Plan.

» Elective programmes not included in the Annual Plan $0.4m

» Mental Health Ringfence funding for NGO sleepover settlements was $0.3m favourable to Plan.

» The sale of five properties has contributed a gain on sale of $0.2m.

» Prior year Electives initiative for Ministry funding the set up for Pharmac medical device procurement was $0.2m favourable to Plan.

EXPENDITURE

Expenditure was $1.9m unfavourable to Plan.

- Personnel costs are $0.7m unfavourable to Plan. A delay in implementing cost reduction strategies to resolve key issues in District Nursing and standardisation of rosters has contributed to the adverse variance in nursing. A higher usage of internal bureau nursing than planned including a higher requirement for specialising and patient watches. A $0.4m allowance for known changes to clinical support has also contributed to the unfavourable variance.
- Outsourced services are $3.7m unfavourable to Plan. This is largely driven by the cover for some of the medical vacancies across a number of specialties in Nelson and Wairau including physicians, general surgery and obstetrics & gynaecology.
- Clinical supplies are $0.4m unfavourable to Plan. This largely reflects increased caseweight volumes in orthopaedics, ear nose and throat, gynaecology and dental procedures.
- Infrastructure & Non-Clinical Expenses are $0.7m favourable to Plan. Increased costs occurred in Software maintenance $1.1m and outsourced maintenance $0.6m, these were offset by an underspend in consultants fees $0.5m, national DHB Insurance savings $0.7m, corporate training $0.4m, and depreciation $0.2m less than budgeted due to assets not purchased during the year.
- Payments to Providers are $2.3m favourable to Plan. Inter-district Outflows are $1.5m favourable to budget, this includes a final favourable wash-up for 2012/13. Expenditure on Hospital Level Care and Rest Home level care continues to increase. Expenditure on Community residential (LTS-CHC) has also increased due to increased client numbers. Receipts from residential care loans have reduced. The overall impact is a reduction in savings of $0.7m. On-going savings against unallocated provisions in Whanau Ora Services and a one off reimbursement of $0.2m received from Te Hauora O Ngati Rarua in December has contributed $0.4m favourable to Plan.

b) Statement of Changes in Equity

The net surplus was $4.4m more than Plan due to the explanations provided in Note 30(a), Statement of Comprehensive Income.

Other Comprehensive income was $0.4m unfavourable to Plan due to the transfer of revaluation reserve to retained earnings on disposal of Golden Bay land and buildings.

Equity injections and repayments were in line with Plan.

c) Statement of Financial Position

CURRENT ASSETS

Current assets are $29.7m more than Plan. Cash & cash equivalents are $32.5m more than Plan and Debtors & Other receivables are $2.1m less than Plan. All deposits are now held by HBL and included in Cash and cash equivalents. Non-current assets held for sale are $0.7m less than Plan, the DHB has been able to sell more of the Assets held for sale than planned. Deffered purchase of budgeted non-current assets has contributed to the budget cash surplus.

NON CURRENT ASSETS

Non-current assets are $20.1m less than Plan. The variance reflects the deferred purchase of budgeted assets.

CURRENT LIABILITIES

Current liabilities are $2.7m more than Plan in total. Creditors and Other payables are $1.1m more than Plan. Short term loans and borrowings are $0.5m more than Plan.

Non Current Liabilities

Non-current liabilities are $6.4m more than Plan. The variance is made up of $8.1m Loans & Borrowings with the inclusion of the new $8.3m Golden Bay Finance Lease, and $1.7m less than Plan in Employee Entitlements with a reduction in non-current personnel liabilities.

EQUITY

Equity is $0.4m more than Plan due to the variances as described in Note 30(b), Statement of Changes in Equity.

(d) Statement of Cash Flows

Cash inflows from Operating Activities were $8.6m more than Plan. Receipts from Ministry of Health and patients were $5.0m more than Plan and payments to suppliers were $2.9m less than Plan for various reasons outlined in Note 30(a).

Cash inflows from Investing Activities were on Plan for the year. Investment in Property, Plant, and Equipment was $14.1m less than Plan, with many planned projects deferred. Investment in intangible assets has also been deferred leaving $7m less than Plan.

Cash outflows from Financing Activities were $0.3m more than Plan. The payment of finance leases liability has increased by $0.3m.

30. MENTAL HEALTH RINGFENCED ACCOUNTS

Nelson Marlborough DHB is required to abide by the restrictions on the use of funding supplied for mental health purposes.

	PARENT & GROUP	
	2014	**2013**
	$000	**$000**
Opening balance of mental health funds	434	417
Excess/(Shortfall) of funding for mental health services over payments	208	17
Adjustment to prior years mental health funds available	-	-
Surplus mental health funds at the end of the financial year which are available for future mental health services	**642**	**434**

31. SEVERANCE PAYMENTS

Nelson Marlborough DHB has made severance payments in accordance with relevant employee contractual obligations. There have been payments to 23 employees totalling $768,990 made in the year ended 30 June 2014 (2013: 5 people, $39,837). See notes 20 and 25.

32. SUMMARY OF REVENUE AND EXPENSES BY OUTPUT CLASS

	PARENT & GROUP		
	2013/14 Budget $000	2013/14 Actual $000	2012/13 Actual $000
Income			
Prevention Services	7,422	7,448	7,563
Early Detection and Management Services	111,200	111,870	112,258
Intensive Assessment and Treatment Services	217,773	222,736	213,903
Support Services	91,477	92,123	86,711
Total Revenue	**427,872**	**434,177**	**420,435**
Expenditure			
Prevention Services	6,564	6,740	6,370
Early Detection and Management Services	111,197	111,016	108,799
Intensive Assessment and Treatment Services	218,006	221,953	219,176
Support Services	92,106	90,075	89,020
Total Expenses	**427,873**	**429,784**	**423,365**
Surplus/(Deficit)			
Prevention Services	858	708	1,193
Early Detection and Management Services	3	854	3,459
Intensive Assessment and Treatment Services	-233	783	-5,273
Support Services	-629	2,049	-2,309
Total Surplus/(Deficit)	**-1**	**4,394**	**-2,930**

33. BOARD MEMBERS' REMUNERATION

The total value of remuneration paid or payable to each Board member during the year was:

	PARENT & GROUP	
	2014 Actual $000	2013 Actual $000
Jennifer Margery Black (Chairperson)	55	40
Judy Crowe	22	21
Ian MacLennan	29	26
John Moore	11	21
Gordon Currie	10	21
Fleur Hansby	10	24
Roma Hippolite	20	21
Gerald Hope	24	22
John Inder	10	21
Patrick Smith	23	23
Russell Wilson	23	22
Jenifer Margaret Black (Wairau)	13	-
Jessica Bagge	12	-
Brigid Forrest	13	-
Patrick Heaphy	12	-

Hinekehu McConnell	6	-
	293	**262**

The total value of remuneration paid or payable to Committee members (excluding Board members) during the year was:

Committee Members (Community Representatives)

Hospital Advisory Committee

Jane Anderson-Bay	1	1
Francis Gargiulo	1	1
Tahi Takao	-	-
Hinekehu Nga McConnell	-	1
Patricia O'Brien	1	-
Dana Wensley	1	-

Community and Public Health Advisory Committee /Disability Support Advisory Committee

Sonny Alesana	4	1
Mabel Grennell	-	1
Judith Holmes	1	1
Glenys MacLellan	1	2
Jos van der Pol	1	1
George Truman	1	1
Jenifer Margaret Black (Wairau)	-	1
Hughes Katu	4	-
Jennifer Gane	-	-
	16	**11**

Footnotes

1) Health Target: 90% by July 2014.
2) Ratio of actual to expected ASH hospitalisations. The expected rate is the national average and a ratio greater than 100% indicates performance worse than the national average.
3) Note: this relates to population 'other [0-74 years]
4) Primary care delivery of podiatry only. Note that this is a community demand driven service.
5) On implementation of new National Pharmacy Service Agreement
6) On implementation of new National Pharmacy Service Agreement
7) PHQ = Patient Health Questionnaire, a depression screening tool – link here: http://www.depression-primarycare.org/clinicians/toolkits/materials/forms/phq9/
8) These elective surgery cwd volumes include elective cardiology and dental
9) Total CWDs as per internal DHB production plan
10) There has not been an increase in elective surgery discharges in 2012/13 as NMDHB has been delivering at a level well above the standard discharge ratios for other DHBs when compared to per head of population
11) This measure is based on OS6 – Elective and arranged day surgery rate
12) This measure is based on OS7 – Elective and arranged day of surgery admission rate
13) This measure is based on OS3 – Elective and arranged inpatient length of stay
14) This measure is based on OS4 – Acute inpatient length of stay
15) This measure is based on OS8 – Acute readmissions to hospital and is the standardised acute readmission rate for unplanned acute readmissions to hospital within 28 days of discharge
16) This is a new measure for 2012/13 and is based on unstandardised data. NMDHB would like to set this target for 2013/14 on standardised data.
17) Number is approximate and includes births in primary maternity facilities
18) Approximately 100 births per annum occur in Golden Bay and Motueka facilities
19) NMDHB offers longer stays for women who have a clinical need.
20) Volume growth here indicates NMDHB is growing capacity to help both local and national cases to support reduced infant mortality
21) Measure based on Perinatal and Maternal Mortality Review Committee (PMMRC) published data – baseline is 2009 at 7.79/1,000
22) Measure based on PMMRC published data – (pregnant up to 42 days post-birth or termination of pregnancy) – baseline is 19.2/100,000 over 2006-9 period
23) Includes LTC-CHC & Residential with paper tool
24) total allocation (is different to what is utilised):
25) Note: 4.5% increase in utilisation for population growth, exclusive of transfers from Canterbury due to the earthquake
26) excludes EQ evacuees and private payers:
27) Excludes short term & Meals on Wheels. Does include Continuing Care.

ANNUAL REPORT

NELSON MARLBOROUGH DHB

2013/2014

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Nelson Marlborough
District Health Board